
SUBJECT: DISCHARGE SUMMARY (Medical Staff Rules and Regulations)

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EFFECTIVE DATE: 1986

REVISION HISTORY: 1989, 1992, 4/95, 4/98, 11/00, 8/02, 5/04, 9/06, 9/08, 02/09, 03/11, 03/13, 4/16

PURPOSE: In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary.

POLICY:

A discharge summary shall be included in the record of any patient:

1. Who is hospitalized greater than two days (including newborns)
2. Who expires, regardless of the length of stay
3. Who has a vaginal delivery and is hospitalized 4 days or greater
4. Who is admitted in the psychiatric/behavioral health units

The Discharge Summary shall contain:

1. Reason for hospitalization
2. Procedures performed and/or significant findings
3. Care, treatment, and services provided
4. Patient's condition and disposition at discharge
5. Information/instructions to the patient and/or family
6. Provisions for follow-up care
7. Principal/Final Diagnosis(es)

A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a two day period of hospitalization. The final progress note must contain:

1. Principal/Final Diagnosis(es)
2. Operative procedures performed
3. Outcome of hospitalization
4. Disposition of the case
5. Provisions for follow-up care

The Discharge Summary must be dictated within seven (7) days of discharge and signed within thirty (30) days following discharge.

The Discharge Summary shall be authenticated by the physician. In the event the Discharge Summary is completed by a nurse practitioner or physician assistant, the MD/DO responsible for the patient during the hospital stay shall authenticate the Discharge Summary.