Discharge Summary Guidelines Fact Sheet

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Introduction

The discharge summary serves as a detailed and comprehensive review of a patient's hospital stay, treatment received, and plans for outpatient care or follow-up. Many electronic health record (EHR) softwares have automatic functions for creating discharge summaries from existing data in the patient's record. While this saves time, it often results in excessively long discharge summaries that are difficult for clinicians to read quickly. This fact sheet outlines what we consider best practices for writing discharge summaries for psychiatric inpatients. The goal is to create a concise document that you would want to read to quickly learn about a new patient that you are admitting.

BASIC DEMOGRAPHICS

- PATIENT NAME
- DATE OF BIRTH
- MEDICAL RECORD #
- DATE OF ADMISSION
- DATE OF DISCHARGE

DISCHARGE DIAGNOSES. Helpful to place this at the beginning of the summary to give readers a quick context.

IDENTIFYING INFORMATION. Provide a snapshot of the patient's demographics, including age, marital status, ethnicity, gender, work status, and primary diagnosis at admission.

CHIEF COMPLAINT AT ADMISSION. Summarize the patient's initial presenting issues/pathology.

HISTORY OF PRESENT ILLNESS AND PAST PSYCHIATRIC HISTORY. You can typically copy and paste this information from your initial admission evaluation. You get extra credit if you edit and improve this section based on additional information you have learned over the course of the hospitalization.

HOSPITAL COURSE. This section is the essence of the discharge summary, since it will help future providers understand how they can most effectively approach and help the patient if and when they are next admitted. Provide a comprehensive review of the patient's hospital stay, including changes in mental and physical health status, and treatments provided. Highlight any significant events or complications during the hospital stay. The course should start with the state of the patient at admission and then cover progress or changes until discharge.

- How long was the admission (clue for probable length of this admission).
- Was the patient cooperative with treatment?
- What was the time course of response to medications?
- Were any prns especially effective?
- Were any medications clearly ineffective?
- Were they active participants, going to groups and interacting with staff and peers?
- Or were they reluctant, staying in their room and resisting significant contact with anyone?
- Were there any behavioral events, such as the need for restraints?
- Were there any legal hiccups, such as signing a 3 day note and triggering a commitment hearing?
- Were family or friends involved in treatment?

MEDICATION CHANGES MADE DURING ADMISSION: While you could argue that this is redundant with some of the information in Hospital Course and in the next section on discharge medications, it is very helpful to detail all medication changes in one place.

MENTAL STATUS ON DISCHARGE. Make sure not to simply copy the admission mental status to this section. The discharge mental status should be improved from admission, and in particular carefully document their level of suicidality/homicidality/impulsivity—all of which should be stable and consistent with safe discharge.

CONSULTATIONS. List any consultations from other medical specialists or mental health professionals during the hospital stay. Include their recommendations and how these were incorporated into the treatment plan.

LABORATORY DATA. Include any significant laboratory or test results obtained during the hospital stay. Highlight any changes or developments from the time of admission.

DISCHARGE DIAGNOSES. List the final diagnosis or diagnoses at the time of discharge, according to the DSM-5 criteria. (While this may seem redundant given that you have started the summary with the discharge diagnoses, it is helpful to repeat this information at the end since many providers will ignore most of the summary and skip right to the end.)

DISCHARGE MEDICATIONS. Detail all medications the patient will continue to take after discharge. Include dosages and the schedule for taking these medications.

DISCHARGE PLAN.

- DISPOSITION: Where will patient go from hospital and how will he/she get there.
- AFTERCARE: Detail the follow-up plan, including any scheduled appointments with mental health professionals or medical practitioners. Include dates, times, and contact information if possible.