Sample Progress Notes and Discharge Summary

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ADMISSION NOTE (Verified)

cc: Family Doctor
Specialist 1
Specialist 2 etc.

DATE OF ADMISSION: Date

PATIENT IDENTIFICATION: Ms. J is a pleasant 76-year-old woman who presented to the Emergency Department from home in London.

REASON FOR REFERRAL: Concern regarding pneumosepsis.

ACTIVE MEDICAL ISSUES:

1. Sepsis secondary to pneumonia.
2. Atrial fibrillation with rapid ventricular rate.
3. Hyponatremia, hypovolemic
4. Migratory polyarthralgia.

PAST MEDICAL HISTORY:

1. Squamous cell carcinoma of the lung, stage III, diagnosed in November of 2019. No surgery was performed given PFTs (FEV1 of 69%, DLCO of 44). They underwent 60 Gy of radiation and 30 fractions to the left lung, as well as treatment with cisplatin and etoposide. Chemotherapy finished February 2020.

Commented [MG1]: Be sure to send copies to the family physician as well as any specialists involved in their care

2. Left leg DVT sustained in February 2020, completed a total course of Edoxaban 60 mg, ultrasound of the leg veins performed on July 23 showed a 2 mm residual clot.
3. Gastroesophageal reflux disease.
4. Remote history of spastic bladder.
5. Remote history of breast cyst.

RECONCILED ADMISSION MEDICATION LIST:

1. Diltiazem 120 mg p.o. daily, new as of 1 week PTA. (**Held on admission)**
2. Metoprolol 50 mg po bid **(newly started on admission)**
3. Apixaban 5 mg oral b.i.d., new as of 1 week PTA
4. Amoxi-Clav 500/125 mg t.i.d., prescribed a 7-day course 1 week PTA (completed)
5. Ceftriaxone 1 g IV q 24 X 7 days to stop on Date
6. Azithromycin 500 mg now followed by 250 mg daily for 5 days to stop on Date
7. CBD oil at bedtime.
8. Tylenol 650 mg q4 hrs PRN started for pain or fever

Commented [MG2]: Key thing to notice is how to indicate what is being held, what is being started and what is being changed. Also put dates on short term meds like antibiotics.

ALLERGIES: Sustained some sort of severe reaction while on paclitaxel chemotherapy. This was switched to cisplatin and etoposide.

SOCIAL HISTORY: Ms. J is a pleasant 76-year-old lady who lives in a home in London with her husband. She gets

assistance from him for some of her IADLs including groceries and medications. She is independent for her ADLs and ambulates independently with no gait aids. She is a former smoker with a total of approximately 15-pack-year history who quit 45 years ago. She does not currently drink alcohol. She does use CBD oil every evening for sleep, but does not use any other recreational drugs.

HISTORY OF PRESENTING ILLNESS: At baseline, despite her underlying malignancy and PFT findings, she has not respiratory symptoms. She presents to the hospital today with a history of 2 weeks of shortness of breath, fever, chills, night sweats and feeling generally unwell. She presented to the St. Joseph's Urgent Care on Date. A CTPA was performed which did not show a PE, but did show a left lower lobe consolidation consistent with pneumonia and she was prescribed a 7-day course of amoxicillin/clavulanate. Ms. J feels that she has not had significant improvement since then. She determined to come in today due to generalized weakness and desire for improvement. She notes that she has a thermometer at home and did not appear to relate any measured temperatures, but was noted to be febrile at triage. As mentioned, she notes a history of increased shortness of breath on exertion, primarily over the past 2 weeks. We note that at baseline, since her treatment for lung cancer, she has

Commented [MG3]: This is essential and often left out. Especially for patients with chronic active disease, it helps you to understand what they are normally like and how this has changed recently/ over time.

had some shortness of breath while talking. Her shortness of breath on exertion is however new. She has also had some mild weakness over the past 2 weeks, does endorse decreased oral intake secondary to decreased appetite over the past 2 weeks. She does have some very mild chest pain, which she says has been present for quite a while, several months, but did improve, and then came back over the past 2 to 3 weeks after sustained coughing fits. She does note that she has quite a sustained cough starting from February that has not changed recently. We do note that this is significant enough to cause her posttussive emesis on a somewhat regular basis, though she was not able to quantify how often.

Ms. J also endorses a history of 6 weeks of migratory polyarthralgia. It initially started in her left hand, where she had an area of erythema that was tender to touch. She did have decreased mobility in that wrist, but was able to sustain some movement. It then spread up into 2 or 3 of her fingers, no particular distribution and limited mobility in them entirely. This pain persisted for 3 to 5 days and then resolved spontaneously. She had a week of no pain, and then the pain appeared similarly in her right hand. This pattern continued and currently she has this pain in her left ankle. She is not able to significantly move her ankle. At this point, it is quite tender and she is having difficulty ambulating given the pain.

Commented [MG4]: Ideally, each active problem listed above should have its own paragraph. Notice how this resident did not write anything about the hyponatremia or atrial fibrillation. Ideally, both should have been discussed at least briefly.

REVIEW OF SYSTEMS: She was positive for 3-day history of mild diarrhea. She did not have any headaches or vision changes. She has no abdominal pain and no recent urinary changes. She does not report any palpitations. She has not had any residual stiffness or other pain in her joints after the inflammatory polyarthralgia fade.

PHYSICAL EXAMINATION:
appeared in mild respiratory distress with tachypnea and some supraclavicular indrawings.
Vitals: At triage, **febrile to 39.7**. **Heart rate of 156 and respiration rate of 30**. Blood pressure 123/73 and satting 96% on 2 litres. On assessment now, temperature is 37.3. Heart rate had decreased down to be 95 to 106. Respiratory rate 22. Blood pressure 106/76, SpO2 97% on 2 litres. Ms. J did desaturate periodically into the high 70s while talking, but when encouraged to breathe through her nose with some pauses in her speech, these did recover.
Respiratory: **Diffuse crackles were present throughout the right lobe of the lung**, with no particular upper versus lower predominance. There were **decreased breath sounds to the left base**, consistent with low lung volumes. There were no crackles in the left lung.
Cardiovascular: Normal S1, S2 with no additional sounds. No peripheral edema. JVP was flat.

Commented [MG5]: This is a very nice touch indicating what they were at their worst or over time in the ED. It gives a better sense of things than just listing what you found when you saw the patient.

Abdomen: Soft, nontender, nondistended.
Extremities: Left ankle examination showed some **mild erythema on the lateral surface of the left ankle**. It was warm to touch and there was significant pain to direct palpation. Ms. J was not significantly able to mobilize her joint due to pain. Examination of the bilateral hands did not show any acute tenderness or limitation in range of motion, though it may show some baseline mild osteoarthritis.

INVESTIGATIONS:

1. VBG showed a pH of 7.43, CO2 of 40, bicarb of 27.2.
2. Electrolytes showed hyponatremia at 129, potassium of 4.6, chloride of 93, bicarbonate 24. Creatinine was 58.
3. Normal white count at 8.1. Hemoglobin at 112, from 127 on May 5. Platelets 422.
4. Chest x-ray shows chronic left-sided volume loss. There are no acute areas of consolidation seen.
5. X-ray of the left ankle shows no fracture.
6. A CTPA on August 31 shows no PE, but does show **left lower lobe consolidation consistent with pneumonia**.

ASSESSMENT AND PLAN: In summary, Ms. J is a pleasant 76-year-old lady presenting from home with fever, tachycardia, tachypnea, in the setting of previously identified left lower lobe pneumonia.

1. Regarding Pneumosepsis: As mentioned, she has a previously diagnosed pneumonia. We do note that there are no acute changes on the chest x-ray, but it did not appear to be visualized to the previous one. There was no other significant infectious source expressed by the patient. We do note her hyponatremia and her diarrhea for the last couple of days and therefore we would add legionella to the differential of organisms, possibly causing this. We think GI source or urine source of infection are unlikely.
    A. We will start ceftriaxone and azithromycin to cover for atypical infections.
    B. We will send urine legionella antigen to rule this out.
    C. We will order urinalysis to ensure no urine source, although we feel that this suspicion is very low given her lack of urinary symptoms.
    D. Given that she is hypovolemic, we have added a 75 mL infusion of Ringer's lactate over 10 hours, in addition to the 1 litre bolus given by the Emergency Department.

2. Regarding AFib and rapid ventricular response: We feel that the cause of this is most likely secondary to hypovolemia and/or infection. Ms. J rate was able to be

Commented [MG6]: Note how for each of the problems, the resident, as relevant addresses the most likely diagnosis, differential diagnosis, underlying cause, plans for further investigation, management and monitoring

controlled with just oral metoprolol 50 mg and therefore an IV push metoprolol was not given.

   A. Given that her rate was not controlled on diltiazem, we have elected to discontinue this and switch her to Metoprolol 50 mg b.i.d.
   B. Given that she is over 65 and is female with a CHADSvasc score of 2, we have elected to continue the apixaban started in the Urgent Care.
   C. Given her presentation with RVR, we will elect to initiate 48 hours of telemetry.
   D. To ensure no additional causes, we have ordered a TSH and an echo, for the team to reassess as needed in the morning.

3. Regarding hyponatremia: We feel that this is most likely secondary to hypovolemia, as Ms. J has a documented decreased oral intake. As mentioned above, we are going to give some maintenance fluids in addition to the bolus that Emerge has already provided. We will reassess her electrolytes tomorrow morning to determine if additional measures are necessary.

4. Regarding migratory polyarthralgia: This pattern is nonspecific, time-limited, and intermittent; she currently only has one painful joint. The multiple joints and subacute time course are not consistent with septic

arthritis. She does have evidence of possible osteoarthritis on examination, and it is possible that this could be related to minor joint trauma causing a more acute flare of pain. A rheumatologic condition remains on the differential.

A. We will order standing Tylenol to provide pain control and help Ms. J with mobilization.
B. We have opted not to send off any rheumatologic workup overnight, and will leave further workup to the morning team.

5. Best Practices:
   A. As Ms. J is already on apixaban, we will not add additional DVT prophylaxis.
   B. Per her wishes, Ms. J is a DNR restricted.
   C. Given that she is on CBD oil at bedtime, but did not bring this, we have opted to add nabilone 1 mg qhs. We could arrange to administer her home CBD oil if it is possible for her husband to drop it off.

6. Disposition: Ms. J will be able to return home to her husband after she has defervesced.

Name,
MD Resident dictating for
Name Attending

Commented [MG7]: be sure to indicate any forms of lines, telemetry, catheters etc. For each be sure to indicate why it is in, how long it is planned to be in and the indication.
E.g. Telemetry for 48 hours to monitor for cause of syncope. If normal after 48 will discontinue.
Foley placed for urinary retention. will treat for constipation and plan a trial of void on DATE.

Commented [MG8]: While it is good to list this, it really should have a few sentences explaining why the patient is making the choice etc.

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CTU PROGRESS NOTE

PATIENT IDENTIFICATION: Ms. M is a 90-year-old female from home with her son and granddaughter presenting with a fever NYD as well as shortness of breath.

DATE OF ADMISSION: Month, day, 20XX

ACTIVE ISSUES:

1. Hypoxemia, likely due to R lower lobe pneumonia
2. Hypotension
3. Mobility
4. Eye infection
5. Confusion

PAST MEDICAL HISTORY:

1. MCA stroke June 22, 2020 with left sided weakness and neglect.
   a. Etiology is ESUS versus small vessel disease
   b. Was in Parkwood for rehab
2. MCV in 1973 with patient suffered from posttraumatic seizures. No history of seizure in the last 10 years.
3. Hypertension.
4. Dyslipidemia
5. Osteoarthritis.
6. Hiatal hernia.
7. Right cataract surgery.

Commented [MG9]: If you use this template, it is easy to cut and paste each day and update each section. Best practice is to make your note, participate in end of day rounds, modify based on what was discussed and sign it. **Please note, you do need to sign your note each day! Otherwise it will not post to be viewed by others.**

Commented [MG10]: Copied from admission note

Commented [MG11]: Copied from admission note but edited based on developing understanding of the problems. The active problem list consists of a combination of new and chronic active problems. To decide if a chronic active problem needs to be on the list in hospital, ask yourself:

1. Does it need monitoring (e.g. DM or heart failure or patient on Coumadin to monitor INR)
2. Are we doing something that might make it less stable (e.g. prednisone in a patient with DM or holding BP meds)

Also include things like lines we have placed (e.g. urinary catheter or PICC line). Including them in the list reminds us to plan when to remove them.

Commented [MG12]: Copied from admission note

SOCIAL HISTORY: The patient lives at home with her son and granddaughter. She mobilized using a walker or a cane around the house. She suffered a stroke recently and did receive rehabilitation therapy at Parkwood Hospital. She continues to remain independent of her ADLs, but her son does help her with groceries and finances. Previous smoker, quit in 1985 – one pack per week.

RECONCILED MEDICATION LIST

1. Pantoprazole 40 mg b.i.d. autosubstituted in hospital for Lansoprazole 30 mg BID
2. ASA 80 mg once daily.
3. Atorvastatin 20 mg once daily.
4. Perindopril 4 mg daily **(HOLD for low BP)**
5. Clobazam 10 mg once daily.
6. Vitamin C 500 mg once daily.
7. Amitriptyline 20 mg once daily
8. Seroquel 25 mg b.i.d.
9. PEG 3350 p.r.n. in hospital medication (no used since admission)
10. cefuroxime 500 mg BID for 7 day course stopping on Date X
11. erythromycin drops x 5 days stopping on Date X
12. Dalteparin 5000 units daily for DVT prophylaxis in hospital

Commented [MG13]: Copied from admission note. Try to sequence like with like (i.e. cardiac meds , DM meds etc.)

Commented [MG14]: If done right, this can be copied from the admission note and then edited daily.

Commented [MG15]: For home meds where the dose was changed or the drug was held be sure to indicate what and why

Commented [MG16]: For prn meds, update daily what they have taken in the past 24 hours

Commented [MG17]: For antibiotics be sure to indicate a stop date and a total duration

IVs

-None currently

ALLERGIES:

1. Cefprozil - tested and told not to take.
2. Penicillin allergy is a rash.

TODAY'S PHYSICAL EXAMINATION:

Vitals: HR71 BP 117/70 RR 18 95% on 1 L NP (Stable over past 24 hours)
General: in bed comfortable, no respiratory distress, alert and oriented x 1 , difficulty with attention. Wearing dentures.
Eye: L eye has periorbital erythema, yellow-green discharge on eyelashes.
Cardio: Normal S1, S2 no murmurs
Resp: Difficult to assess due to positioning, GAEB in the upper lobes, no crackles or wheezes.
Abdo: Abdomen soft, non tender, non distended

Hypoxemia, likely due to R lower lobe pneumonia: Not on oxygen at baseline, no history of COPD or asthma. No wheeze, but short of breath on admission to the emergency department. CXR showed no pulmonary edema. CT showed no PE but demonstrated infectious cause of shortness of

Commented [MG18]: If running maintenance be sure to list what you are running and the, why you are running it and the plan for discontinuing it

breath as well as a nodule in the R lower lobe. Had two documented fevers over 38.0 degrees in ER. Given one dose of levofloxacin by ER. Normal lactate. Swabbed for COVID. Switched to ceftriaxone q 24 hours. Placed on O2 in emerg. **Has allergies to multiple antibiotics.**

Updates: Fever has resolved. Shortness of breath has resolved. On O2 1-1.5 L NP. Blood cultures show no growth on day 1. Breath sounds difficult to appreciate today due to positioning but had good air entry bilaterally. Was satting 90% on 1 L but once took deep breaths and repositioned NP, rose to 95%. Lung nodule on CXR discussed with the patient. COVID negative. Dropped to 76% after exertion and oxygen was increased to 1.5L NP.

Plan:

1. Switched to cefuroxime 500 mg BID oral to step down as appears to be improving.
2. Wean off oxygen.
3. Consider referral to Adverse Drug Reactions clinic due to multiple antibiotic allergies.
4. Arrange F/U for lung nodule with CT in 3-6 months.

Hypotension: Treated for hypertension at baseline, on perindopril 4 mg daily. Was hypotensive (90/50s) at

admission. Received 500 mL bolus in ER, no AKI. Eating well. Received 1000 mL RL. Suspended perindopril.

Updates: BP 117/70 today. Not symptomatic currently. Euvolemic/dry on examination.

Plan: Continue to hold perindopril.

Mobility: At baseline, uses a walker or cane to mobilize. Has not gotten out of bed since admission.

Plan: PT referral in place for this patient.

L eye inflammation: 3 days prior to admission, had a migraine headache and had a nap, waking up to crusting and erythema around the L orbit. Had periorbital redness around the left eye with some crusting with discharge on the eyelashes.

Updates: No pain. Continues to have erythema, crusting and purulent discharge from L eye. No vision changes.

Plan: erythromycin drops to treat infection.

Confusion: No confusion or dementia at baseline. Previous stroke. Family states has become confused in hospital before. Was not oriented to person or place since admission but no fluctuating level of consciousness.

Update: According to her nurse, she has had a better night last Pm and today appears to be oriented X 3.

Assessment/Plan: Initial delirium likely secondary to infection and hypoxia. Continue to monitor

Best Practices: DVT prophylaxis has been started, 5000 units of dalteparin. Code status was discussed and the patient wishes to be DNR basic.

Commented [MG19]: be sure to indicate any forms of lines, telemetry, catheters etc. For each be sure to indicate why it is in, how long it is planned to be in and the indication.
E.g. Telemetry for 48 hours to monitor for cause of syncope. If normal after 48 will discontinue.
Foley placed for urinary retention. will treat for constipation and plan a trial of void on DATE.

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DISCHARGE SUMMARY (Verified)

cc: Family Doctor
Specialist 1
Specialist 2 etc.

DATE OF ADMISSION: Date
DATE OF DISCHARGE: Date

Mrs. Mu is a 90-year-old female from home with her son and granddaughter who initially presented with fever NYD as well as shortness of breath.

DISCHARGE DIAGNOSIS: Right lower lobe pneumonia.

ACTIVE ISSUES IN HOSPITAL:

1. Hypoxemia, likely due to the right lower lobe pneumonia.
2. Hypotension on a background of HTN.
3. Mobility.
4. Eye infection.
5. Confusion.
6. Right lower lobe lung nodule.

PAST MEDICAL HISTORY:

1. MCA stroke June 22, 2020 with left sided weakness and neglect.
    a. Etiology is ESUS versus small vessel disease
    b. Was in Parkwood for rehab

Commented [MG20]: Be sure to send copies to the family physician as well as any specialists involved in their care

Commented [MG21]: Copied from admission note and modified, if needed based on other information learned in hospital (i.e. the admission note is not always accurate)

2. MCV in 1973 with patient suffered from posttraumatic seizures. No history of seizure in the last 10 years.
3. Hypertension.
4. Dyslipidemia
5. Osteoarthritis.
6. Hiatal hernia.
7. Right cataract surgery.

DISCHARGE MEDICATIONS:

1. Quetiapine 25 mg oral 2 times daily.
2. ASA 81 mg daily.
3. Amitriptyline 20 mg oral daily with supper.
4. Atorvastatin 20 mg oral daily.
5. Clobazam 10 mg oral daily at bedtime.
6. Cyanocobalamin 500 mcg oral daily.
7. Pantoprazole 40 mg oral BID
8. Cefuroxime 500 mg BID to complete a 7-day course ending on Date

DISCONTINUED MEDICATIONS:

1. Perindopril 4 mg oral daily (due to persistent hypotension in hospital).

COURSE IN HOSPITAL:

Pneumonia: At baseline, Mrs. M. is not on any oxygen, has no history of COPD or asthma, but does have a history of

Commented [MG22]: For newly prescribed meds, be sure to indicate why and, if self-limited, duration and end date. Be sure to also indicate any changes to chronic home meds (e.g. metoprolol 25 mg bid decreased from 50 mg bid)

Commented [MG23]: Must include. Be sure to also hand write a prescription indicating the discontinuation because power chart does not generate discontinuation scripts

Commented [MG24]: This is key! For patients with chronic active medical problems, a description of baseline function is especially important. For example, if she had COPD, what has it been like in the past year. What can they do and not do etc.

smoking approximately 1 pack of cigarettes per week, last smoking in 1983. On admission to the hospital, she was short of breath and was febrile. CT chest showed no PE, but showed a right lower lobe pneumonia as well as a nodule in the right lower lobe. She was given 1 dose of levofloxacin by the Emergency Department. She was also swabbed for COVID, but was negative. She was switched to ceftriaxone, and stepped down cefuroxime 500 mg b.i.d., which is to be stopped on date after a 7-day course. During her hospital stay, she had difficulty weaning off oxygen. The day before discharge, she developed a one-time, low-grade fever of 38.0 degrees Celsius, which was investigated with chest x-ray which showed no gross changes from previous chest x-ray, and there was no other clinical suggestion of infection. At discharge, she was able to achieve an oxygen saturation up to 100% while lying in bed without oxygen.

Hypotension: During her stay, she was consistently hypotensive or normotensive and initially received several fluid boluses. Her Perindopril was suspended due to hypotension and was not restarted because all of her BPs were below 120 systolic.

Mobility: At baseline, she uses a cane or walker to mobilize. She was seen by PT and OT during her stay to help with

Commented [MG25]: Depending on the problem, always be sure to flag key findings at the time of discharge. In other patients, this might be their JVP, what their lungs sounded like or how much pedal edema they had.

Commented [MG26]: Secondary minor issues should be mentioned but do not necessarily require a lot of detail.

mobilization. Both of these services will be seeing her in the community as she was not back to baseline at discharge.

Left eye inflammation: Two days prior to admission, she developed crusting and erythema around her eye. She also had periorbital redness on the eye with some crusting and discharge on the eyelashes. She was placed on erythromycin drops q.i.d. for 5 days, which cleared any signs of infection.

Confusion: She has no confusion or dementia at baseline, but does have history of stroke. The family did state that she has a history of becoming confused in hospital. Throughout her hospital stay, she had fluctuating mentation, at times not being oriented to time or place. However, on discharge, she was oriented to person and place. It was thought that infection and being in the hospital may have contributed to her confusion. At time of discharge, she was slightly off baseline, but the team felt that she would likely reorient better at home where her confusion would resolve.

Lung nodule: She was found to have a lung nodule of her right lower lobe. This was explained to her and her family that it may be due to an infectious cause or may be a change in the lung parenchyma or may be a signal that there may be an underlying malignancy. A repeat CT scan in 3 months is recommended.

RECOMMENDATIONS AND FOLLOW-UP PLANS:

1. Pneumonia: This appears to have fully resolved. There is no need for follow-up CXR. She has 2 days of antibiotics to complete
2. HTN: At baseline she has HTN. Throughout her stay we have held her Perindopril 4 mg oral daily. We have asked her to see her family physician in 1-2 weeks to reassess and we have notified her Family Physician who has also agreed with this plan
3. Lung nodule: As noted above, a CT scan has been ordered with results cc'd to her family physician. We have contacted their office and they have agreed to follow-up with her and her family on the results.
4. Mobility: PT and OT will see her in the community for an at home assessment and ongoing support.

Commented [MG27]: This is always a good thing to do wen asking someone else to do follow-up.

It was a pleasure being involved in this patient's care. Should there be any questions arising from this Discharge Summary, please do not hesitate to contact Dr. Attending Physician.

Name
Clinical Clerk/resident for,
Dr Name

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Discharge Planning and the D/C Note

Milton dictating Paradise Lost to his Daughters.

Discharge planning and the D/C note represent a very important aspect of inpatient care. This teaching brochure has been designed to help guide you through the process.

Prepared by:§
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§ Last updated June 2020

D/C Checklist:

Discharge planning begins at the time of admission. However, if not already done, don't forget to do the following:

1.<u>Day before D/C</u>

- Fill out PODS and discuss D/C plans with patient and/or their families.
  - What happened in hospital
  - Changes in meds
  - What to expect
  - Complications to watch for and what to do if they occur.
- Inform/arrange for home care (LHIN) etc. when appropriate.
- Contact patient's family doctor and/or pertinent specialists (if relevant).
- Plan Scripts keeping in mind the following:
  - No change to their prior medication regimen- reconcile but do not provide new script.
  - If changing doses – in the comments section indicate that this is a change from the prior dose (e.g. increased from prior dose of…)
  - Don't forget to use the **limited use codes** when required.
  - **If pre-hospitalization meds have been stopped, you will need to hand-write these onto the electronic script at the time of discharge** (PowerChart does not allow discontinue scripts). The alternative is to create non-formulary script which can be used for discontinuing medications.
  - Don't provide scripts for PRN meds unless truly indicated post-discharge.

2. Day of D/C

- Do any tasks not already done. (e.g., review PODS with the patient.)
- Review scripts with senior.
- Ensure that appropriate follow-up has been arranged and that the patient is aware of these plans. This includes the need for follow-up tests or to review pending tests.
- Dictate the D/C summary.
  This needs to be done on the same day as the discharge.

  Note: if you know that you will need to edit it, please inform the attending of this need and be sure to do the edits the very next day so that it can be signed off and sent to the family physician within 48 hours of d/c. **Prior to a weekend or post-call** day, it is ok to pre-dictate a d/c note so that the person who best knows the patient is doing the summary.

Note: Patients who have **died** also need a dictated death summary! If you are on call when this occurs, and you are not just cross- covering, as a courtesy to your teammates, please dictate the summary. If not, let the team senior know the next morning so they can ensure that it gets done.

Dictation

1. Prior to Dictating:

- Be sure that you are clear on the discharge plans for the patient (you may need to discuss these with the senior prior to dictating your note).
- Make a list of all the names (first* and last) of physicians who should receive a copy of this note (attending, family physician, any specialists who were involved in their care while they were in hospital or who follow them on an outpatient basis). Also include a copy to places like their nursing home.
- Find a quiet place to dictate
- Remind yourself to "speak slowly" and spell key words (esp. physician last names, drug names and doses etc.)

2. Starting your dictation

- Identify self, role, date, patient name, PIN # and their D.O.B.:
  "this is John Smith PGY1 dictating for Dr. M. Goldszmidt on April 1st 2020. This is a dictation on Mr. John Doe, PIN # 1234567, DOB 05/01/69)".
- Identify all physicians who should receive a copy of the D/C summary.
- Be sure to include their **first name/initial as well as their last name!**
- Also indicate:
  - Date of Admission:
  - Date of Discharge:

* For transcription services to send it out, you need at least a first initial. If the physician is from another city, please also specify which one.

3. <u>Dictation Format</u>†

I. Most Responsible Diagnosis

II. Patient Identification
Mr. Doe is a 66 y.o who was admitted from home where he lives with his wife…His active problem list includes:

III. Active Problems list
(1) CAD with CHF
(2) Acute on Chronic renal failure
(3) Type II DM etc.
Note: This is not all past medical problems, only active ones. It may include social issues such as needs for more home supports and **complications arising in hospital** etc.

IV. Past Medical/Surgical History Include a full list of their past history. Some of these may be same titles as the active problems.

V. RE_____
(A.k.a. History of Active Problems dealt with in hospital) For this series of sections, start with most important active problem (usually same as "most responsible diagnosis"). Be sure to dictate new headings for each one:
*New paragraph "*RE: CHF*" new line*... Try to keep paragraphs relatively brief (i.e., 3-5 sentences/paragraph).

† When dictating the first heading, indicate that you wish them to put all headings in "ALL CAPS". Also, say *"new heading"* for each new section.

For each Active Problem be sure to include:

- Synopsis of original presentation including only pertinent +ves and –ves from the history, physical and investigations.
  (Complete history and physical does not belong here!)
- Course in hospital for that problem ***including functional status*** and pertinent ***physical findings*** at time of D/C. Also include results of any consultations or relevant results (labs, echo, CT, PFT etc.).
- Note: For 2º problems, this may be brief

VI. Summary of Investigations (optional)
Only include major investigations like echos, CTs, blood cultures etc.

VII. Discharge Meds:
Goal is to have one list of meds that clarifies how they have changed since admission. It should only include Prn's that they will be using at home:

1. *Metoprolol 25 mg bid (↑ from 12.5 mg bid)*
2. *lasix 20 mg bid (↓ from 40 mg bid)*
3. *Plavix 75mg OD (new) …*
4. *In addition, lisinopril and celebrex were D/C'd*

Note: Do not include a separate list of admission meds.
Do mention drug allergies (including the reaction type).

VIII. Recommendations& Follow-up:

This is the most important section so take your time here. For each problem, give it its own section and go in the same order you used above.

1. RE DM:
2. RE CHF:

For each, be sure to clarify:

- What the problem is:
  - Diagnosis, severity and prognosis (if relevant)
- Plans for managing problem:
  - Current therapies
  - Planned therapies
  - Planned/Pending investigations
  - What has been discussed with the patient/family (Goals of Care, resuming activities, lifestyle changes, monitoring issues (sugars, daily weights etc.) and prognosis (when relevant!)
  - Who will provide follow-up, what they will be doing and why for example:

    "Because of the risk of hyperkalemia and worsening renal dysfunction, we have asked the family doctor to re-check electrolytes in two weeks"‡
  - Also be sure to indicate:
    - Disposition (nursing home etc.)
    - Services arranged (LHIN etc.)
    - Results of Goals of care discussions

Abbreviated Dictation Format

- Introduction: Identify self, role, date, patient name, PIN # and their D.O.B.
- Copies to: Chart, Family physician, other specialists (first and last names)

DATE OF ADMISSION:

DATE OF DISCHARGE:

I. MOST RESPONSIBLE DIAGNOSIS:

II. I.D.: Mr. Doe is a

III. ACTIVE PROBLEMS LIST:

   i. _____

   ii. _____, etc.

IV. OTHER PAST MED/SURGICAL HISTORY

V. RE: "TITLE FOR ACTIVE PROBLEM #1"

(Include abbreviated HPIs, course in hospital and functional status at time of D/C for each active problem)

RE: "Title Active problem #1"

RE: "Title Active problem #2" etc.

VI. SUMMARY OF INVESTIGATIONS

VII. MEDS AT TIME D/C & ALLERGIES

VIII. RECOMMENDATIONS & FOLLOW- UP

- Dictate by problem (*1. Re Diabetes:)*
- State final opinion of what problem is
- Plans for managing problem:
  - Current/Planned therapies
  - Planned/Pending investigations
  - What patient/family have been told
  - Who will provide follow-up and what they will be doing
  - Also indicate
    - Condition at discharge including disposition (nursing home, home…)
    - Services Arranged (home care etc.)
    - Results of Goals of care discussions

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