



## INODAYA Hospitals - Kakinada

Documentation code:  
INHH/AAC.Doc.No-34

### Policy on Discharge Summary Content

Prepared Date: 05/09/2023

Reference: AAC.14.NABH Standards – 5<sup>th</sup> Edition

Issue date: 05/09/2023

Issue No:2

Review NO:01

Review Date: 04/09/2024

#### 1.0 PURPOSE

To define the content of discharge summary

#### 2.0 SCOPE

This procedure is applicable to discharge summary which is given to patients at INODAYA Hospital Kakinada.

#### 3.0 RESPONSIBILITIES

Medical Administration, Treating Doctor or his / her team member or DMO and PRE are responsible to implement and comply with this procedure.

#### 4.0 PROCEDURE

- 1.1. Discharge Summary is to be provided to the patients at the time of discharge.
- 1.2. Patient's medical record contains a copy of Discharge Summary or Death Summary (when possible or retained in soft copy in server or CD).
- 1.3. Content of the Discharge Summary to include:
  - 1.0 Patient's name
  - 2.0 Unique identification number
  - 3.0 Date of admission and date of discharge
  - 4.0 Reason for admission or chief complaints.
  - 5.0 Significant positive and negative points of history and findings.

Prepared by: 	Verified by: 	Approved by: 
Dr.D.N.S.Prakash	Mrs.G..Lakshmi Lavanya	Dr.G.Rammohan
Medical Director	Accreditation Coordinator	Managing Director



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- 6.0 Diagnosis.
- 7.0 Patient condition at the time of discharge.
- 8.0 Investigation results.
- 9.0 Procedure(s) performed.
- 10.0 Medications.
- 11.0 Other treatment given.
- 12.0 Follow up advice, medications and other instructions.
- 13.0 When and how to obtain urgent care.
- 14.0 Contact numbers of doctors (for urgent care).
- 15.0 Cause of death (in case of death summary).

#### 5.0 Preparation of Discharge Summary:

Once the treating doctor declares that the patient “Fit to be Discharged” (after discussing with patient / patient attendant), the PRE coordinates with DMO / treating doctor (or) his / her team member for the preparation of Discharge Summary.

DMO / Treating doctor (or) his / her team member to prepare discharge summary in specified format based on the information from patient and Inpatient Record.

The draft is prepared and forwarded to treating doctor or his / her team member for necessary corrections or authorization.

#### 6.0 RECORDS

Prepared by: 	Verified by: 	Approved by: 
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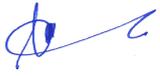
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6.0 Inpatient Record.

7.0 Discharge Summary.

### Document Revision History

DOCUMENT REVISION HISTORY		
Version	Date of issue	Reason for Revision
Original version - 1	10/03/2022	Prepared 5 <sup>th</sup> edition
Revised version - 2	05/07/2023	Periodic revision and update
Revised version - 3		
Revised version - 4		
Revised version - 5		

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