

	INODAYA Hospitals - Kakinada		Documentation code: INHH/AAC.Doc.No-37
	Policy on Discharge Summary Content		Prepared Date: 11/11/2025
	Reference: AAC.13.NABH Standards – 6 th Edition		Issue date: 11/11/2025
	Issue No:01	Review NO:0	Review Date: 10/11/2026

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 HospitalKakinada.

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 POCEDURE

- 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.
 - 6.0 Diagnosis.

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Medical Director	Accreditation Coordinator	Managing Director

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- 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

6.0 Inpatient Record.

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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 th edition
Revised version - 2	05/07/2023	Periodic revision and update
Revised version - 3		
Revised version - 4		
Revised version - 5		

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