**SAMPLE NAME: BACK & LEG PAIN - DISCHARGE SUMMARY**

**Description:** Bilateral L5 spondylolysis with pars defects and spinal instability with radiculopathy. Chronic pain syndrome.

**ADMISSION DIAGNOSIS:** Bilateral L5 spondylolysis with pars defects and spinal instability with radiculopathy.

**SECONDARY DIAGNOSIS:** Chronic pain syndrome.

**PRINCIPAL PROCEDURE:** L5 Gill procedure with interbody and posterolateral (360 degrees circumferential) arthrodesis using cages, bone graft, recombinant bone morphogenic protein, and pedicle fixation. This was performed by Dr. X on 01/08/08.

**BRIEF HISTORY OF HOSPITAL COURSE:** The patient is a man with a history of longstanding back, buttock, and bilateral leg pain. He was evaluated and found to have bilateral pars defects at L5-S1 with spondylolysis and instability. He was admitted and underwent an uncomplicated surgical procedure as noted above. In the postoperative period, he was up and ambulatory. He was taking p.o. fluids and diet well. He was afebrile. His wounds were healing well. Subsequently, the patient was discharged home.

**DISCHARGE MEDICATIONS:** Discharge medications included his usual preoperative pain medication as well as other medications.

**FOLLOWUP:** At this time, the patient will follow up with me in the office in six weeks' time. The patient understands discharge plans and is in agreement with the discharge plan. He will follow up as noted.


**SAMPLE NAME: CARDIO/PULMO DISCHARGE SUMMARY**

**Description:** A 49-year-old man with respiratory distress, history of coronary artery disease with prior myocardial infarctions, and recently admitted with pneumonia and respiratory failure. (Medical Transcription Sample Report)

**ADMISSION DIAGNOSIS:**

1. Respiratory arrest
2. End-stage chronic obstructive pulmonary disease.
3. Coronary artery disease.

**DISCHARGE DIAGNOSIS:**
2. Chronic obstructive pulmonary disease.
3. Congestive heart failure.
4. History of coronary artery disease.
5. History of hypertension.

**SUMMARY:** The patient is a 49-year-old man who was admitted to the hospital in respiratory distress, and had to be intubated shortly after admission to the emergency room. The patient’s past history is notable for a history of coronary artery disease with prior myocardial infarctions in 1995 and 1999. The patient has recently been admitted to the hospital with pneumonia and respiratory failure. The patient has been smoking up until three to four months previously. On the day of admission, the patient had the sudden onset of severe dyspnea and called an ambulance. The patient denied any gradual increase in wheezing, any increase in cough, any increase in chest pain, any increase in sputum prior to the onset of his sudden dyspnea.

**ADMISSION PHYSICAL EXAMINATION:**
GENERAL: Showed a well-developed, slightly obese man who was in extremis.
NECK: Supple, with no jugular venous distension.
HEART: Showed tachycardia without murmurs or gallops.
PULMONARY: Status showed decreased breath sounds, but no clear-cut rales or wheezes.
EXTREMITIES: Free of edema.

**HOSPITAL COURSE:** The patient was admitted to the Special Care Unit and intubated. He received intravenous antibiotic therapy with Levaquin. He received intravenous diuretic therapy. He received hand-held bronchodilator therapy. The patient also was given intravenous steroid therapy with Solu-Medrol. The patient’s course was one of gradual improvement, and after approximately three days, the patient was extubated. He continued to be quite dyspneic, with wheezes as well as basilar rales. After pulmonary consultation was obtained, the pulmonary consultant felt that the patient’s overall clinical picture suggested that he had a significant element of congestive heart failure. With this, the patient was placed on increased doses of Lisinopril and Digoxin, with improvement of his respiratory status. On the day of discharge, the patient had minimal basilar rales; his chest also showed minimal expiratory wheezes; he had no edema; his heart rate was regular; his abdomen was soft; and his neck veins were not distended. It was, therefore, felt that the patient was stable for further management on an outpatient basis.

**DIAGNOSTIC DATA:** The patient’s admission laboratory data was notable for his initial blood gas, which showed a pH of 7.02 with a pCO2 of 118 and a pO2 of 103. The patient’s electrocardiogram showed nonspecific ST-T wave changes. The patient’s CBC showed a white count of 24,000, with 56% neutrophils and 3% bands.

**DISPOSITION:** The patient was discharged home.

**DISCHARGE INSTRUCTIONS:** His diet was to be a 2 grams sodium, 1800 calorie ADA diet. His medications were to be Prednisone 20 mg twice per day, Theo-24 400 mg per day, Furosemide 40 mg 1-1/2 tabs p.o. per day; Acetazolamide 250 mg one p.o. per day, Lisinopril 20 mg. one p.o. twice per day, Digoxin 0.125 mg one p.o. q.d., nitroglycerin paste 1 inch h.s., K-Dur 60 mEq p.o. b.i.d. He was also to use a Ventolin inhaler every four hours as needed, and Azmacort four puffs twice per day. He was asked to return for follow-up with Dr. X in one to two weeks. Arrangements have been made for the patient to have an echocardiogram for further evaluation of his congestive heart failure later on the day of discharge.
MEDICAL TRANSCRIPTION DISCHARGE SUMMARY SAMPLE

REASON FOR ADMISSION: Chest pain, syncopal episode.

HISTORY OF PRESENT ILLNESS: This is a 51-year-old female admitted through the emergency room with syncopal episode with chest pain and also noted to have epigastric discomfort.

HOSPITAL COURSE AND TREATMENT: The patient was admitted and started on Lovenox and nitroglycerin paste. The patient had serial cardiac enzymes and ruled out for myocardial infarction. The patient underwent a dual isotope stress test. There was no evidence of reversible ischemia on the Cardiolite scan. The patient has been ambulated. The patient had a Holter monitor placed but the report is not available at this time. The patient has remained hemodynamically stable. Will discharge.

Diagnostic Impression:
1. Chest pain, ruled out myocardial infarction.
2. Syncope, workup in progress.
3. History of hyperlipidemia.

FURTHER PLAN: Will discharge.

DISCHARGE MEDICATIONS: Include:
1. Prevacid 30 mg p.o. every day.
2. Lipitor 10 mg every day.
3. Premarin 0.625 mg every day.
4. Enteric-coated aspirin 325 mg every day.

Barlow’s and Ortolani’s Tests (signs).

Test done on infants/newborns: (Sometimes dictated on Discharge Summaries)

Barlow’s test identifies unstable hip that lies in the reduced position but can be passively dislocated (and hence unstable).

Ortolani’s sign is the palpable sensation of the gliding of the femoral head in and out of the acetabulum.

Source: http://www.mt-stuff.com/discharge_summary.html
DATE OF DISCHARGE:

DISCHARGE DIAGNOSES:

1. Intrauterine gestation at term.
2. History of two previous cesarean sections.
3. Delivered viable male infant.

PROCEDURES PERFORMED:

1. Repeat low transverse cesarean section.
2. Bilateral tubal ligation.

COMPLICATIONS: None.

PERTINENT FINDINGS/HISTORY AND PHYSICAL: Refer to the detailed admission dictation.

The patient is a (XX)-year-old gravida 6, now para 3-0-3-3 female, who was admitted at term for repeat cesarean section and sterilization. The patient had previous cesarean sections for labor arrest, for an infant weighing 9 pounds 12 ounces and elective repeat. The patient strongly desired repeat cesarean section. She had been appropriately consented. She had also wished to have a tubal ligation and signed the appropriate consent forms. She is well aware of the risks, options, failure rates and permanency of sterilization procedures. Her antenatal course was significant for development of A1 diabetes with blood sugars in excellent control, on diet only. The patient declined genetic screening because of advanced maternal age.

LABORATORY INVESTIGATIONS: Please refer to the admission dictation for the patient's antenatal labs. The patient's admission hemoglobin was 11.1 with hematocrit of 33.4 and platelet count 196,000. Her postoperative hematocrit was 32.2.

HOSPITAL COURSE: The patient was admitted on the morning of her scheduled surgery. Detailed informed consent was again reobtained. All consents were signed. Under spinal anesthesia, uncomplicated repeat low transverse cesarean section and bilateral tubal ligation were performed. A viable male infant with Apgars of 9 and 9 with birth weight of 8 pounds 6 pounds was delivered. The patient's postoperative course was uneventful. She remained afebrile with stable vital signs. She returned quickly to good ambulation and regular diet. She had normal GI function return. Her incision healed nicely. Her lochia was light.

Discharge examination revealed negative HEENT, neck, heart, lung, extremities and abdominal examinations.

CONDITION ON DISCHARGE: Stable.

DISPOSITION: Discharged to home.

DISCHARGE INSTRUCTIONS:

ACTIVITY: Slow increase as tolerated. No heavy lifting. Strict pelvic rest.

DIET: Regular.
MEDICATIONS: Colace p.r.n., Tylenol p.r.n. and prenatal vitamins. The patient is breastfeeding. Prescriptions for Percocet 325/5 tablets, #30, no refills, 1 to 2 p.o. q.4-6 h. p.r.n. pain and ibuprofen 800 mg, #20, no refills, 1 p.o. q.8 h. p.r.n. pain.

Follow up as an outpatient in the office in 1 week.

The patient has received routine verbal instructions and agrees to comply. She knows to contact us immediately should she develop any signs or symptoms of complications such as fevers, chills, drainage from the incision, abdominal distention, nausea, vomiting, heavy vaginal bleeding, leg redness or swelling, chest pain, chest pressure or shortness of breath.

Source: http://sites.google.com/site/medicaltranscriptionsamples/ob-gyn-discharge-summary-medical-transcription-sample-reports

ADDITIONAL EXAMPLES:

- http://sites.google.com/site/medicaltranscriptionsamples/ob-gyn-discharge-summary-medical-transcription-sample-reports
- www.dundee.ac.uk/medther/Stroke/Disc.doc