Example 1

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

Date of Encounter

DOE, JANE	00000123	02-13-2014	02-17-2014
Patient Name	Med Rec No.	Admit Date	Discharge Date

Physician: John A. Doe, M.D.
Dictated By: John A. Doe, M.D.

Allowed Provider Type

ADMISSION DIAGNOSIS:
Right knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Right knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
02/14/2014: Total Right knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mrs. Doe is a pleasant 60-year old female who has had a longstanding history of right knee arthritis. She has complained of right sided knee pain since January 2013. Since then, her ambulation has been limited by pain and she has pain at night that interrupts sleep. Pain medication, ibuprofen and hydrocodone, have been unsuccessful in relieving her pain for the last 6 months. Workup did show reduction in the right knee joint space. She initially failed conservation treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension, Gout.

PAST SURGICAL HISTORY:
Hysterectomy.

Meets the requirements for documenting: (1) the need for skilled services; (2) the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Coumadin 4 mg daily; blood draw for INR ordered for 2/20/2014.

DISCHARGE CONDITION:
Upon discharge Mrs. Doe is stable status post right total knee replacement and has made good progress with her therapies and rehabilitation. Mrs. Doe is to be discharged to home with home health services, physical therapy and nursing visits, ordered. The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new Coumadin medical regimen.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of her son. Diet is regular. Activity, weight bear as tolerated right lower extremity. The patient prescribed Coumadin 4 mg a day as the INR was 1.9 on discharge with twice weekly lab checks. Resume home medications. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Doe in two weeks.

Transcribed by: A.M 02/17/2014
Electronically signed by: John A. Doe, M.D. 02/17/2014 17:52