

## Example 4 – Part 1 of 2

### AAA HOSPITAL DISCHARGE SUMMARY -DEPARTMENT OF SURGERY-

Smith, John                      00000124                      04-14-2014  
Patient Name                      Med Rec No.                      Admit Date  
Physician: Sam Bone, M.D.                      04-18-2014  
Dictated By: Sam Bone, M.D.                      Discharge Date

Date of Encounter

Allowed Provider Type

#### ADMISSION DIAGNOSIS:

Left knee osteoarthritis.

#### DISCHARGE DIAGNOSIS:

Left knee osteoarthritis.

#### CONSULTATIONS:

1. Physical Therapy
2. Occupational Therapy

#### PROCEDURES:

04/14/2014: Left knee arthroplasty.

#### HISTORY OF PRESENT ILLNESS:

Mr. Smith is 70 y.o. male who presents with left knee osteoarthritis for 10 years. Over the past three years the pain has steadily increased. It was initially controlled by ibuprofen and steroid injections. In the last year he has required ibuprofen and Percocet to ambulate and this treatment has been unsuccessful in relieving pain for the last 6 months. His ambulation has been limited by pain and he has pain at night that interrupts sleep. Workup did show reduction in the left knee joint space. He has failed conservative treatment and has elected to proceed with surgical treatment.

#### PAST MEDICAL HISTORY:

Hypertension

#### PAST SURGICAL HISTORY:

Inguinal hernia repair

#### DISCHARGE MEDICATIONS:

Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Lovenox 30mg sq every 12hours for 6 more days.

#### DISCHARGE CONDITION:

Upon discharge Mr. Smith is stable status post left total knee replacement and has made good progress with his therapies and rehabilitation. Mr. Smith is to be discharged to home with home health services, physical therapy and nursing visits, ordered. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition and teaching of Lovenox injections.

#### PATIENT INSTRUCTION:

The patient is discharged to home in the care of his wife. Diet is regular. Activity, weight bear as tolerated left lower extremity. 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. Bone in two weeks.

Transcribed by: A.M 04/18/2014

Electronically signed by: Sam Bone, M.D. 04/18/2014 18:31

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

**Please see OASIS (Part 2 of 2) for homebound status.**