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Discharge Summaries

The Joint Commission has established standards (Standard IM.6.10, EP 7) outlining the components that each hospital discharge summary should contain:

- **Reason for hospitalization**: Chief complaint, including a description of the initial diagnostic evaluation
- **Significant findings:** Admission and discharge diagnoses (as well as those conditions resolved during hospitalization)
    - All diagnoses documented in coding based diagnostic language
    - List all possible and probable diagnoses in the discharge summary
- **Procedures and treatment provided:** Consults, procedure findings, surgical findings, test results, etc.
- **Patient's discharge condition:** How the patient is doing at time of discharge
- **Patient and family instructions:** Includes discharge medications, follow up needed, list of all medications changed and/or discontinued, dietary needs, follow up tests or procedures
- **Attending physician's signature and date of service**

The Discharge Summary should not introduce new information, nor should it conflict with previous documentation substantiated in the record.
Remember that most records are coded and billed within 24 hours of the patient's discharge

Studies have demonstrated a trend toward a decreased risk of readmission when the discharge summary arrives before the outpatient follow-up visit takes place. The study, by van Walraven and colleagues (*J Gen Intern Med*. 2002; 17:186-192), found a 0.74 relative risk of decreased rehospitalization for these patients.