

**Date:** [Date]

**RE: Patient Discharge Summary and Transition of Care**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Patient ID/MRN:** [ID Number]

**Date of Admission:** [Admission Date]

**Date of Discharge:** [Discharge Date]

**To:** [Primary Care Physician Name]

**Clinic Name:** [Clinic Name]

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## 1. Discharge Diagnosis

[Primary Diagnosis]

[Secondary Diagnoses/Comorbidities]

## 2. Hospital Course Summary

[Brief summary of clinical presentation, key tests performed, and treatments administered during the stay.]

## 3. Procedures and Interventions

[List any surgeries or major procedures performed.]

## 4. Medications

**New Medications:** [List names, dosages, and frequency]

**Changed/Discontinued Medications:** [List changes]

**Medications to Continue:** [List chronic medications]

## 5. Test Results Pending

[List any labs, cultures, or imaging results still awaited.]

## 6. Follow-Up Plan and Appointments

- **PCP Follow-up:** Required within [Number] days.
- **Specialist Follow-up:** [Specialty Name] on [Date/Time].

- **Laboratory/Imaging:** [List required outpatient tests].

## **7. Patient Instructions and Activity Restrictions**

[Dietary restrictions, wound care, physical activity limits, etc.]

## **8. Discharge Condition**

[Stable / Guarded / Improved]

Should you have any questions regarding this transition, please contact the discharging unit at [Phone Number].

Sincerely,

[Provider Signature]

[Provider Name and Title]

[Hospital/Facility Name]