Date: [Current Date]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Medical Record Number: [MRN]
Admission Date: [Start Date]
Discharge Date: [End Date]

To: [Recipient Name/Primary Care Physician]

Final Diagnosis:

- Primary: [Diagnosis Name/ICD Code]
- Secondary: [Diagnosis Name/ICD Code]

Reason for Admission:
[Brief description of symptoms and clinical presentation at intake.]

Hospital Course and Treatment Provided:
[Summary of therapeutic interventions, individual/group therapy, and clinical progress.]

Discharge Medications:

Medication Name	Dosage	Frequency	Purpose
[Drug Name]	[MG]	[Times per day]	[Indication]

Condition at Discharge:
[Improved/Stable/Baseline]

Follow-up Care Plan:

- **Outpatient Appointment:** [Provider Name] on [Date/Time]
- **Therapy Referral:** [Provider Name/Agency]
- **Laboratory Work:** [Required tests if applicable]

Safety Plan and Emergency Instructions:
Patient has been provided with a safety plan. In case of psychiatric emergency or suicidal ideation, the patient is instructed to call 988, contact the crisis line at [Phone Number], or report to the nearest emergency room.

Sincerely,

[Physician Signature]
[Physician Name, Credentials]

[Facility Name]
[Contact Information]