

**Hospital Name:** [Insert Hospital Name]

**Department:** Obstetrics and Neonatology

**Date:** [Insert Date]

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## **DISCHARGE SUMMARY: HIGH-RISK MATERNITY AND NEWBORN CARE**

### **1. PATIENT INFORMATION**

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

**Date of Birth:** [DOB]

**Date of Admission:** [Date]

**Date of Discharge:** [Date]

**Newborn Name:** [Newborn Name/Gender]

**Gestational Age at Birth:** [Weeks/Days]

### **2. CLINICAL DIAGNOSIS**

**Maternal Diagnosis:** [e.g., Preeclampsia, Gestational Diabetes, Placenta Previa]

**Delivery Method:** [e.g., Emergency C-Section, Induced Vaginal Delivery]

**Neonatal Diagnosis:** [e.g., Prematurity, Respiratory Distress Syndrome, Neonatal Jaundice]

### **3. SUMMARY OF CARE & PROCEDURES**

**Hospital Course:** [Brief summary of treatments, surgeries, or NICU stay details]

**Medications Administered:** [List significant medications used during stay]

### **4. DISCHARGE MEDICATIONS**

**Maternal:** [Medication Name, Dosage, Frequency]

**Newborn:** [Medication Name, Dosage, Frequency]

### **5. POST-DISCHARGE INSTRUCTIONS**

**Maternal Care:** [Incision care, activity restrictions, monitoring blood pressure]

**Newborn Care:** [Feeding schedule, temperature monitoring, specialized equipment instructions]

## 6. FOLLOW-UP APPOINTMENTS

- **Obstetrician:** [Date and Time]
- **Pediatrician/Neonatologist:** [Date and Time]
- **Specialist (if applicable):** [Date and Time]

## 7. EMERGENCY WARNING SIGNS (Seek immediate care if:)

**Maternal:** Severe headache, vision changes, heavy bleeding, chest pain, or fever.

**Newborn:** Difficulty breathing, poor feeding, lethargy, yellowing of skin, or fever.

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**Discharging Physician:** [Name and Credentials]

**Signature:** \_\_\_\_\_

**Contact Number:** [Hospital Contact Info]