Date: [Date]

Patient Name: [Patient Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

DISCHARGE SUMMARY: DRUG DESENSITIZATION PROTOCOL

Attending Physician: [Physician Name]

Department: [Allergy/Immunology or Infectious Disease]

1. Procedure Overview
The patient underwent a Rapid Drug Desensitization protocol for **[Name of Medication]** on **[Date]**. This procedure was performed due to a documented history of hypersensitivity to this medication and a critical clinical need for its administration.

2. Protocol Outcome
[ ] Protocol successfully completed without adverse reaction.
[ ] Protocol successfully completed with minor managed reactions (e.g., localized rash, mild pruritus).
[ ] Protocol aborted due to: [Reason].

3. Current Medication Status
As of [Time], the patient has reached the target therapeutic dose of **[Dose Amount/Frequency]**. The patient is currently in a temporary state of "desensitization" (drug tolerance).

4. Critical Instructions for Maintenance
IMPORTANT: To maintain this state of tolerance, the medication must be administered on a strict, continuous schedule.

- **Dose:** [Dosage]
- **Interval:** Every [Number] hours.
- **Missed Dose:** If a dose is missed or delayed by more than [Number] hours, the patient may lose tolerance. **Do not restart the medication at the full dose.** Contact the Allergy team immediately for instructions.

5. Warning Signs
Seek immediate medical attention if any of the following occur:

- Difficulty breathing or wheezing
- Swelling of the lips, tongue, or throat
- Widespread hives or severe skin rash
- Dizziness or feeling of faintness

6. Follow-up Care
[Follow-up instructions and appointments].

Physician Signature: _____

Contact Number: [Phone Number]