DISCHARGE CARD

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A Discharge card, is a clinical summary written by a health care provider at the end of the treatment, it may be end of a stay at a hospital or an end of series of treatment for the patient. It is a document of communication between the health care provider and the aftercare provider.

What should a discharge card have?

1. Why the patient came to hospital.
2. Condition on arrival.
3. The results of any tests that were conducted during the stay at the hospital.
4. The treatment the patient received at the hospital in exact chronological manner
5. The medication that is needed to be taken after the discharge is given.
6. The aftercare that is needed. E.g. physiotherapy
7. The next date of follow-up.
8. Sign of the attending Physician.

Important points to note that are needed to fill a Discharge certificate:

1. Should be filled or supervised by the consultant In-charge.
2. It should have a clear sign of the consultant who is In-charge.
3. Operation notes if mentioned have to be correct, otherwise just mention the name of the operation and give separate notes in details if asked for.
4. If any complication is expected ask the patient to report immediately, e.g. when a patient of head injury-concussion is discharged after observation, write on the discharge card - **to report if Vomiting, head ache, giddiness, or convulsion.**
5. Instructions while discharge **MUST** be clear.
6. If implants are used, the details of implants and implants related discharge instructions should be mentioned.
7. It is important to note that discharge cards should have the hospital name, address and phone number as it acts like an advertisement and a visiting card of your hospital.

To conclude, Discharge card is a document that is most referred to in the court of law. It is the only document hand written that is carried home by the patient, so spare enough time on it and complete the document completely and thoroughly, only than should you hand it over to the patient.