Short-Term Acute Care Discharge Report

Patient Information

Patient Name:	_____	**DOB:**	____ / ____ / _____
Medical Record #:	_____	**Admission Date:**	____ / ____ / _____
Discharge Date:	____ / ____ / _____	**Attending Physician:**	_____

Hospital Course Summary

_____
_____
_____
_____

Diagnoses at Discharge

- _____
- _____
- _____

Procedures Performed

- _____
- _____

Medications at Discharge

Medication	Dosage	Instructions
_____	_____	_____
_____	_____	_____
_____	_____	_____

Discharge Instructions

- _____
- _____
- _____

Follow-Up Appointments

- _____
- _____

_____
Physician Signature & Date

Patient/Guardian Signature & Date