Patient Discharge Form

HOSPITAL INFORMATION

Hospital/facility name: _____ Address: _____

Emergency contact information:

PATIENT INFORMATION

Contact information: _____ Primary care physician: _____

Contact information: _____

ADMISSION AND DISCHARGE DETAILS

Admission date: _____ dd / mm / yyyy

Reason for admission:

Diagnosis:

Treatments received:

Discharge summary:

FOLLOW-UP CARE

Follow-up appointment date/time: _____

Dietary recommendations:

Activity restrictions:

Referrals:

MEDICATION INSTRUCTIONS

Medication name: _____ Dosage: _____

Frequency: _____

Special instructions:

Medication name: _____ Dosage: _____

Frequency: _____

Special instructions:

Medication name: _____ Dosage: _____

Frequency: _____

Special instructions:

PATIENT ACKNOWLEDGMENT

I, the undersigned, acknowledge that I have received and understand the information provided in this discharge form. I am aware of the follow-up appointments, medications, and care instructions.

Patient name: _____ Date: _____ dd / mm / yyyy

Signature: