COUNTY OF LOS ANGELES **DEPARTMENT OF HEALTH SERVICES**

HARBOR-UCLA MEDICAL CENTER

SUBJECT: DISCHARGE/TRANSFER/INTERIM DEATH RECORDS **POLICY NO. 607**

PURPOSE:
To ensure that a discharge, transfer and/or death record are maintained.

POLICY:
A Discharge Summary is required for all patients admitted as inpatients within the Medical Center. When a patient is transferred to another acute care facility, a Transfer Summary must be completed.

When a patient has been in the hospital for 30 days, an Interim Summary must be completed. An additional Interim Summary will be completed at the end of each additional 30-day period during which the patient remains admitted.

A Death Summary must be completed in all death cases.

A Psychiatric Discharge Summary must be completed for all psychiatric admissions.

The Health Care Information Committee must approve the format used for the Discharge Summary, the Transfer Summary, the Interim Summary, and the Death Summary.

DEFINITION:
For purposes of this policy, a hospital "day" is the difference between the date in question (e.g., discharge date) and the date of admission. A "postpartum day" is the difference between the date in question and the date of delivery (birth).

PROCEDURE:

I. Inpatient Admissions

- A Discharge Summary is required for all inpatient admissions.

EFFECTIVE DATE: 1979 **SUPERSEDES:**
REVISED: 9/86, 10/92, 2/96, 2/99, 2/05, 1/14
REVIEWED: 9/86, 2/96, 5/96, 2/99, 2/02, 6/10, 1/14, 12/19
REVIEWED COMMITTEE: Health Care Information Committee

APPROVED BY:

Kim McKenzie, RN, MSN, CPHQ
Chief Executive Officer

Anish Mahajan, MD

Anish Mahajan, MD
Chief Medical Officer

Nancy Blake, PhD, RN, NEA-BC, FAAN
Chief Nursing Officer

2. Newborn Record:
   - A discharge note may be used alone for well patients whose postpartum length of stay does not exceed two postpartum days, in the case of vaginal births; or four postpartum days, in the case of Cesarean deliveries; or for well term infants whose discharge is delayed beyond these limits only because of maternal problems.
   - In the case of patients who do not meet the criteria above, a Discharge Summary is required.

3. Psychiatric Discharge Record:
   - For all psychiatric admissions, a Discharge Summary is required.

B. Transfer Record:

I. A transfer record requires a dictated summary.

II. A patient transfer for non-medical reasons (e.g. private insurance) requires notification the patient's preferred contact person (next of kin, significant other etc.).

Prior to the transfer of a patient for non-medical reasons, the hospital must do the following:

- Ask the patient if there is a preferred contact person to be notified.
- Make reasonable attempts to contact the person and alert him/her about the transfer.
- If the patient is unable to respond, the hospital must make a reasonable effort to ascertain the identity of the preferred contact or next of kin and make a reasonable attempt to contact the person and alert him/her about the transfer.
- The hospital must document in the medical record all attempts to notify the preferred contact/next of kin.
- If the patient does **NOT** wish anyone to be contacted, the patient's wishes must be documented in the medical record.

C. Interim Record:

An Interim Summary of the patient's course suffices.

D. Death Record:

I. A death record requires and a Death Summary.

II. FORMAT FOR HOSPITAL DISCHARGE/TRANSFER/DEATH SUMMARY:

A. Patient name
B. Hospital medical record number
C. Service
D. Date of admission
E. Date of discharge
F. Patient disposition
   - Discharge to home/self; transfer to another institution; death

G. Principal diagnosis
   - Diagnosis, after study, shown to necessitate this hospital stay. If diagnosis includes malignancy, include stage if known.

H. Additional diagnoses, including complications
I. Procedures and/or studies performed with dates and with results, if known
   - Include transfusions
   - If diagnosis including malignancy, comment on extent found and/or resected
J. Medications in use at discharge
   - Discharge medications, plus ongoing prescriptions
   - Include contraceptive method if appropriate
K. Known allergies/sensitivities
   - Rh and type, rubella status if appropriate
L. Hospital course (use narrative form)
   - Patient identification: ages, sex, racial or ethnic group, gravidity/parity, language, social or occupational features
   - Initial complaint
   - Reason patient appeared to require acute hospitalization
   - Important features of hospital stay
   - Discharge planning
   - Condition at discharge
M. Diet
N. Ambulation
O. Disability
P. Supplies and durable medical equipment sent with patient
Q. Discharge instructions and special precautions given (list)
R. Outpatient follow-up plans
   - Clinics
   - Physical, psychiatric, or radiation therapy; chemotherapy
   - Home visits or other nursing/social services arrangements
S. Resident physician primarily responsible for care during this admission
T. Attending physician primarily responsible for care during this admission
U. Person dictating this report
   - Name
   - Staff identification number
V. Signature(s) (manual or electronic)

ATTACHMENT I

COUNTY OF LOS ANGELES

DEPARTMENT OF HEALTH SERVICES

HARBOR - UCLA MEDICAL CENTER
PHYSICIAN DISCHARGE REPORT

Date of admission: ____________

Date of discharge: ____________

☐ Discharge to home/self
☐ Discharge to another facility
☐ Patient death

Principal diagnosis*: ____________

____________ ICD9 code: ____________

*(The diagnosis shown, after study, to have necessitated this admission)

Reason patient was admitted at this time: ____________

____

Additional diagnoses — ICD9 codes

Procedures/studies performed — CPT code — ICD9 code

Discharge Medications (name, dosage, schedule, & duration):

Allergies:

Followup appointments (clinic name, location, date, time):

Discharge instructions (if applicable)
☐ Smoking cessation
☐ Nutritional counseling
☐ Weight monitoring
☐ Dry weight ____________

Immunizations given: ☐ Not applicable ☐ Pneumococcal ☐ Influenza ☐ Other ____________

Special precautions/notes:

Patient's condition on discharge: ☐ Good ☐ Fair ☐ Poor ☐ Deceased

Disability anticipated: ☐ none ☐ permanent ☐ temporary until: ____________ ☐ partial (see special precautions)

☐ Discharge summary dictated: Date: Time: ____________ (Dictation confirmation #) ☐ Copy sent to referring provider

☐ Discharge plan discussed with the attending physician who concurs with discharge.

Provider responsible for dictating discharge summary: ____________ (Provider Name) ____________ (Staff ID #) ____________ (Service)

Providers primarily responsible for this patient's care:

Resident: ____________ (First name) ____________ (Last name) ____________ (Staff ID #) ____________ (Service)

Attending: ____________ (First name) ____________ (Last name) ____________ (Staff ID #) ____________ (Service)

Provider Printed Last Name:			
Provider Signature:		ID#:	
Date: __ __ – __ __ – __ __		Time: __ __ : __ __	AM / PM

ORIGINAL - FILE IN MEDICAL RECORD
CANARY - PATIENT
PINK - PROVIDER

PHYSICIAN DISCHARGE REPORT

HH295 (11-13-08)

F = First Exam
D = Discharge Exam

A = Active
R = Resolved

COUNTY OF LOS ANGELES

ATTACHMENT II

DEPARTMENT OF HEALTH SERVICES

F	D	GENERAL CONDITION
		GA by Exam:
		Abnormal
		Normal
F	D	SKIN
		Cyanosis ☐ Body ☐ Extremities
		Pallor
		Plethora
		Jaundice ☐ Face ☐ Chest ☐ Abd
		Bruising
		Birthmarks
		Petechiae
		Erythemia Toxicum
		Meconium Staining
		Milia
		Edema
		Pustular Lesions
		Other:
		Normal Skin
F	D	HEAD-NECK
		☐ Micro ☐ Macrocephaly
		Abnormal Facies
		Cephalohematoma
		Caput ☐ Due to Vac Ext
		Abnormal Sutures
		Abnormal Fontanelle
		Scalp Electrode Mark
		Scalp Abscess
		Nasal Flaring
		Abnormal Oral Cavity
		Other:
		Normal Head-Neck
F	D	EARS
		Abnormal Location R L
		Abnormal Form R L
		Other:
		Normal Ears
F	D	EYES
		Funduscopic ☐ Normal ☐ Abn
		Cataracts R L
		Abnormal Retina R L
		Conjunctivitis R L
		Scleral Hemorrhage R L
		Other:
		Normal Eyes
F	D	LUNGS-THORAX
		Respirations, Rate
		F: D:
		↑ A-P Diameter
		Grunting
		Retractions
		Stridor
		Breath Sounds ↓ R L
		Rales
		Abnormal Breasts R L
		Other:
		Normal Chest

F	D	CARDIOVASCULAR
		Heart Rate
		F: D:
		Precordial Thrill
		↓ Capillary Filling
		Arrythmias
		Murmur, Present
		Murmur, Absent
		Displaced Apical Beat
		Cardiomegaly
		Femoral Pulses ☐↓ ☐↑
		Brachial Pulse ☐↓ ☐↑
		Other:
		Normal Heart
F	D	ABDOMEN
		Distended
		Palpable Mass
		Type:
		Hepatomegaly
		Splenomegaly
		Diastasis Rectus
		Hernia
		Type:
		Single Umbilical Artery
		Other:
		Normal Abdomen
F	D	GENITAL-ANAL
		Ambiguous
		Hypospadius
		Testes Undescended R L
		Imperforate Anus
		Hymenal Tag
		Other:
		Normal Genital-Anal Area
F	D	NEUROLOGIC
		Decreased Activity
		Increased Activity
		Asymmetric Movement
		Hypotonia
		Hypertonia
		Abnormal Cry
		Moro Abnormal
		Paralysis
		Other:
		Normal Neurologic
F	D	MUSCULOSKELETAL
		Abnormal Back-Spine
		Hip Click R L
		Fracture R L
		Type:
		Malformation
		Other:
		Normal Musculoskeletal

FIRST EXAM	DATE	TIME	DISCHARGE EXAM	DATE	TIME
Length	cm	%	Length	cm	%
Weight	gms	%	Weight	gms	%
Head Circ	cm	%	Head Circ	cm	%
COMMENTS			COMMENTS		
Sig:			Sig:		

DISCHARGE SUMMARY

CONDITION ☐ Neonate ☐ Infant ☐ Death, Date/Time:
☐ Health, No Disease ☐ Disease Active
Autopsy: ☐ Requested ☐ Denied ☐ Permitted ☐ Pending

Multiple Birth ☐ No Twin ☐ A ☐ B Triplet ☐ A ☐ B ☐ C

Sex ☐ M ☐ F ☐ Unk | PKU, T-4, Galactosemia Screen ☐ Yes ☐ No

A/R	DIAGNOSIS	
	☐ Term ☐ Pre ☐ Post ☐ SGA ☐ AGA ☐ LGA	

OPERATIVE PROCEDURES

☐ Circumcision

TRANSPORT TO: DATE:

FEEDING ☐ Breast ☐ Similac ☐ Evaporated Milk ☐ Enfamil ☐ SMA ☐ Other:

MEDS ☐ Vitamins ☐ Iron ☐ Fluoride_____

REFERRAL	Name/Clinic	Wks	INSTRUCTIONS
PMD			
PHN			
Hosp Follow-up			
Commun Health			
Specialty			

WIC ☐ Referred ☐ Known to WIC

DISCHARGE ☐ Home with mother ☐ Home after mother ☐ AMA ☐ Placement ☐ Other

Address Phone

Person receiving this patient

SIGNATURES

Physician Number

Hospital of Discharge Number

Admit Date/Time | Discharge Date/Time

Nurse Number

IMPRINT I.D. CARD (NAME MRUN CLINIC/WARD)

T-HS2199

NEWBORN PHYSICAL/DISCHARGE 12

HS-2199 (10/2006)

ATTACHMENT III

COUNTY OF LOS ANGELES

DEPARTMENT OF HEALTH SERVICES

HARBOR - UCLA MEDICAL CENTER

Admission Date: _____ Discharge Date: _____ ☐ Discharge home/self ☐ Discharge to facility ☐ Patient death	Diagnosis: (the diagnosis shown, after study, to have necessitated this admission) Axis I _____ DSM _____ Medical Audit _____ Axis II _____ _____ _____ Axis III _____ ICD _____ _____ Axis IV _____ Axis V _____

Nature of problem/illness/event that required admission: _____

Course in hospital: _____

Procedure/studies performed:	CPT Code	ICD9 Code

Recommended follow-up: _____

ORIGINAL - FILE IN MEDICAL RECORD
CANARY - PATIENT
PINK - MIS (ROOM 1-P-9)

PSYCHIATRIC DISCHARGE RECORD/PLAN

M899 (3-08)

CONTINUED ON NEXT PAGE

HARBOR - UCLA MEDICAL CENTER

Discharge medications: (name, dose, schedule, & side effects)

Allergies: ☐ None ☐ Specify _____

NAME	DOSE	SCHEDULE	SIDE EFFECTS

Follow-up Appointments: (Medical & Psychiatric)

Name of Clinic	Appointment Date	Time	Referral Sent

Expected course of recovery: (If patient follows discharge plan)

Next few days _____

1 Week _____

1-2 Months _____

_____

Patient given a copy of the Discharge Record/Plan: ☐ Yes ☐ No

Patient's conservator given a copy: ☐ Yes ☐ No ☐ N/A

Patient informed of the right to designate another person to receive a copy: ☐ Yes ☐ No

Patient Designee: ☐ None ☐ _____ given a copy: ☐ Yes ☐ No
(name)

Disability anticipated: ☐ None ☐ Permanent ☐ Temporary until: _____

Discharge summary dictated: Date: _____ Time: _____ _____
Dictation Confirmation #

Provider responsible for dictating discharge summary: _____ _____ _____
(Provider name) (Staff ID#) (Service)

Provider completing this report: ☐ Same ☐ Other: _____ _____ _____
(Provider name) (Staff ID#) (Service)

Providers primarily responsible for this patient's care:

Provider Printed Last Name		Provider I.D. Number
Date	Time	Pager Number
Provider's Signature		

ORIGINAL - FILE IN MEDICAL RECORD
CANARY - PATIENT
PINK - MIS (ROOM 1-P-9)

PSYCHIATRIC DISCHARGE RECORD/PLAN

M899 (3-08)