Georgia Health Sciences Health System
DISCHARGE ORDER / Instruction Summary

Admission Date: ________ Discharge Date: ________ Discharge Time: ________

Attending Physician: _______________ MCG Referring MD: _______________

Primary Care MD: _______________ Primary Care MD Phone/Fax: _______________

Record all diagnoses/conditions/comorbidities impacting care.

**Principal Diagnosis:** 1. 
**Other Diagnoses:**
2. 
3. 
4. 
5. 
6. 
7. 
8.

Record all operations and procedures during this stay.

**Principal Procedure:** 1. 
**Other Procedures/Operations:**
2. 
3. 
4. 
5. 
6. 
7. 
8.

Discharge Medications and Dosages:
1. _______________ Daily 2x day 3x day 4x day As Needed
2. _______________ Daily 2x day 3x day 4x day As Needed
3. _______________ Daily 2x day 3x day 4x day As Needed
4. _______________ Daily 2x day 3x day 4x day As Needed
5. _______________ Daily 2x day 3x day 4x day As Needed
6. _______________ Daily 2x day 3x day 4x day As Needed
7. _______________ Daily 2x day 3x day 4x day As Needed
8. _______________
9. _______________
10. _______________
11. _______________
12. _______________
13. _______________
14. _______________

**INSTRUCTIONS TO PATIENT AT TIME OF DISCHARGE:**

❤ Diet:

❤ ☐ Daily Weights (All Heart Failure Patients) If weight increases _______________ over target weight of _______________ then _______________ until weight returns to target weight. If weight decreases _______________ below target weight of _______________ then _______________.

❤ Call Healthcare Provider or 911 if the following symptoms worsen: ________________________________

❤ Physical Activity: ________________________________

❤ Smoking Cessation: ☐ Patient Counseled ☐ Other ________________________________

Special Instruction Sheets: ☐ Angioplasty/PCI ☐ Pacemaker/Defibrillator Placement ☐ Coumadin ☐ Heart Failure

**Patient Teaching** (Treatments/Needs): ________________________________

❤ Follow-up Care: ☐ Clinic _______________ Ph. # _______________ Dr. _______________ Date/Time: _______________

☐ Clinic _______________ Ph. # _______________ Dr. _______________ Date/Time: _______________

☐ Referring Physician Office Care: ________________________________

☐ Other Agency/Facility: ________________________________

**Physician’s Signature:** _______________________________ Date: _______________

Discharge Summary Dictated: ☐ No ☐ Yes Date: _______________ MIN#: _______________

**Nurse Reviewer:** _______________________________ Date: _______________

The above has been explained to me and I have had an opportunity to ask questions.

☐ Patient ☐ Parent ☐ Guardian’s Signature: _______________________________ Date: _______________

THIS CERTIFIES THAT I HAVE BEEN RELEASED BY THE STAFF OF THE MCG HEALTH SYSTEM AND THAT I AM TAKING ALL OF MY PERSONAL BELONGINGS (VALUABLES AND CLOTHING) WITH ME.

DATE: _______________ SIGNED: _______________________________ WITNESS: _______________________________