Institute Logo, Name, and address

DISCHARGE SUMMARY

CATEGORY : GENERAL/ JAY

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** |  | **HOSPITAL NO.** |  |
| **AGE/SEX:** |  | **ADMISSION NO.** |  |
| **ADDRESS:** |  | **WARD** |  |
|  |  | **DATE OF ADMISSION** |  |
| **Mob No.:** |  | **DATE OF DISCHARGE** |  |
| **D.O.B. :** |  | **WEIGHT ON ADMISSION** |  |
| **INFORMANT** |  | **WEIGHT ON DISCHARGE** |  |

|  |  |
| --- | --- |
| **CONSULTANTS:** | **SPECIALITY : PEDIATRICS**  **RESIDENTS:** |

|  |
| --- |
| **DIAGNOSIS:** |

**Brief history, pertinent physical data :**

Patient was brought to paediatric OPD with complains of:

* N/H/O fever, cough, cold

**Treatment history and past history:** patient was taken to

**Birth history:** single / Female / full term / Spontaneous Vaginal delivery / BW- 2.5 kg / hospital delivery / baby cried immediately after birth / No history of NICU admission/ No any significant perinatal history

**Immunization history**: completed upto current age (according to his mother). No immunization records are available. BCG scar is present.

**Developmental history**:

Studying in standard

Development normal according to age

No history suggestive of delayed developmental milestones

**Family history:**

No H/O similar illness in family

No H/O contact TB

|  |  |  |  |
| --- | --- | --- | --- |
| **Anthropometry** : | **Observed** | **Expected** | **Percentile** |
| **Weight (kg)** |  |  |  |
| **Height(cm)** |  |  |  |
| **Body mass index (kg/m2)**  **Head circumference (cm)** |  |  |  |

**Vitals on examination :**

|  |  |
| --- | --- |
| * **T** – Normal * **PR**– 72/min * **RR** –18/min * **Spo2 :**- 100% * **BP -**110/70 mmhg * Pallor present. No icterus, no cyanosis, no lymphadenopathy, no edema. | **Systemic examination**   * **RS**– B/L air entry equal, no adventitious sound,no visible distress * **CVS**– S1S2 normal, no murmur * **P/A –** soft ,non tender. Liver- not palpable, spleen- not palpable * **CNS** – active alert , both eyes pupil reacting to light . |

**Treatment summary :**

|  |  |
| --- | --- |
| IV Fluids  Inj PCM  Inj Pantoprazole  Inj Ondansetron |  |

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**Condition on Discharge :**

|  |  |
| --- | --- |
| * **T** – Normal * **PR** – 78/min * **RR** – 18/min * **Spo2 :**- 100% * **BP:-** * Pallor present.No Icterus, no cyanosis, no lymphadenopathy, no edema. | **Systemic examination**   * **RS**– B/Lair entry equal, no adventitious sound * **CVS**– S1S2normal, no murmur * **P/A– S**oft ,non tender. Liver- not palpable, spleen- not palpable * **CNS**– Active alert , both eyes pupil reacting to light . |

**Advice on discharge :**

* Tab/ Syp paracetamol as and when required for fever
* Tab/Syp ondansetron (4mg) as and when required for vomiting
* Tab pantoprazole(40 mg) as and when required
* Take plenty of fluids
* Danger signs explained for immediate followup

**Follow up:** follow up in pediatrics opd on /09/2019 (Monday and Thursday )

Bring immunization card on follow up

**Consultant’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I have understood the instructions given about the medication dosage and post-discharge care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient / relative signature)

**Contact urgently if patient becomes/develops vomiting/ convulsions/ ear bleeding/ high grade fever or unconscious.**