

Patient Discharge Form

Hospital information

Hospital/facility name:

Address:

Emergency contact information:

Patient information

Name:

Date of birth:

Medical record number:

Contact information:

Address:

Primary care physician:

Contact information:

Admission and discharge details

Admission date:

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

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:

Signature: