UVA Health

0400002

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

DOWNTIME after Visit Summary/Discharge Report

Location/Address: ____________________

Date of Discharge: __________ Time of Discharge: __________ Name of Attending Provider: ____________________

Reason for visit/hospitalization: ____________________

Allergies: ____________________

Current Medication List (note changes from previsit/admission list – provide instructions to start, stop or continue)

Medication Name	Dose	Route	Frequency	Start Date/Time	Continue	Discontinue

(See Continuation sheet on back for list of more medications)

Immunizations given: ____________________

Referrals made: ____________________

Follow up plan: ____________________

Discharge instructions *(may include diet, pain management, supplies, equipment, community services, etc.)*:

____

____

(Inpatient/ED) I have received and understand all instructions and prescriptions (if any):

____
PRINT PATIENT/SURROGATE NAME

____________________ ________ ________
PATIENT/SURROGATE SIGNATURE DATE TIME

____
PRINT RN/PHYSICIAN NAME

____________________ ________ ________
RN/PHYSICIAN SIGNATURE DATE TIME

____
PRINT INTERPRETER NAME

____________________ ________ ________
INTERPRETER SIGNATURE DATE TIME

If you need a Crisis Hotline, Call 1-800-784-2433 or 211 in Virginia.
In case of emergency, call 911 or go to the nearest Emergency Department.

WHITE COPY - EMR YELLOW COPY - PATIENT

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Continuation of Current Medications:

Medication Name	Dose	Route	Frequency	Start Date/Time	Continue	Discontinue