

Writing Discharges

This is always a challenging part of clinics because each clinician has certain preferences for how the discharges should be written. Below are some some general comments for discharge writing, and what information goes in each section, but keep in mind that each clinician will instruct you as to the exact format each section should have.

INITIAL SECTION: Make sure this is complete – fill out clinician’s name, your name, the service, and do not forget the **discharge date** (if it is an outpatient, just put today’s date).

DIAGNOSES: Think of this as the problem list. You should list any definitive diagnoses, and additional major problems without a definitive diagnosis. Significant historical problems are also important and should be listed, as they may be contributing to current illness or may affect testing or treatment options for the patient. The comments column is for further clarification of each problem/diagnosis. You may include further description of the problem, top differentials, whether a condition is poorly controlled, stable, or resolving, or other pertinent information. Rather than writing “Cause unknown”, write the remaining differentials. Comments in this section should be very brief however, as the details will come in the referral report.

FEEDING and EXERCISE: If you check the specific instructions box for either of these sections, make sure to give specific instructions!

MEDICATIONS: ***It is very important to fill out this section completely.*** List all medications, newly prescribed or ones that the patient is already taking. In your history, you should collect all of the names, doses, routes of administration, frequency, and duration. This information needs to be recorded in the discharge. Make sure to put the pill size (mg, mcg, etc.) in the size/quantity section (mg/mL for oral suspension), and how many pills (or mLs for oral suspension) you are sending home.

Example: You send home twenty 250 mg tablets (written 250 mg/#20 in size/quantity section) of Clavamox, and want to give 500 mg twice daily. Instructions: START to give 2 tablets (500 mg) by mouth every 12 hours for 5 days.

The instructions section is also where you write what the drug is for and side effects.

Example: Clavamox is an antibiotic. It may cause GI upset. Please give with food.

ALL medications should be listed, and based on if it is a new medication, a new dose, or a change of dose, use descriptors in the instructions (i.e, START, CONTINUE, INCREASE, or DECREASE to give...). If a medication is being discontinued at that visit, it is helpful to write the medication and instructions to “DISCONTINUE this medication”. This system is *extremely* helpful for the next clinician and student seeing the case to understand the recent drug history of the patient.

TESTS:

All tests should be listed in this section in the left hand column (with the date listed if the animal is hospitalized over multiple days). There is variation in what clinicians prefer to be reported in the results column, but in general, it is best to report any abnormal values (with their reference ranges listed), and any normal values that are relevant. Below are some pointers for what to report with minimum database tests.

CBC:

- PCV, TP, platelets, and WBC numbers should be reported
- If PCV is low, report MCV and MCHC, and RBC morphology for better description
- If platelets are low, report MPV or note enlarged platelets and manual observations
- If WBCs are abnormal, describe specific WBCs (eos, neuts, etc.) that are abnormal
- If you suspect a disease that should cause a change in a cell line, report the cell line, even if normal – this helps build a case for or against the disease process

Chemistry profile:

- Report all abnormal values
- If the whole profile is normal, you can report within normal limits
- If a previous values was abnormal and is now normal, report the new normal value
- Report values (normal or abnormal) that support or refute an important differential

Urinalysis:

- Report method of collection (voided, cystocentesis, catheterization), USG, pH, Dipstick findings (heme, protein, bilirubin, glucose, ketones), and notable sediment findings (i.e. 10-25 RBC/hpf, sediment otherwise unremarkable)

Include tests such as radiographs, ultrasound, blood pressure, ECG and other findings in this section. With all tests, remember to report values and reference ranges. Radiographs and ultrasound findings should be reported in full, rather than just reporting the radiographic or ultrasonographic diagnosis section. It is important for the referring veterinarian and the client, as well as clinicians and students seeing the case in the future, to actually see the description of findings, as the clinician needs to prioritize rule-outs depending on the clinical presentation of the case. If results are not back yet, write “results pending” in the results column (for imaging findings, write “preliminary report” and write in the preliminary findings or your description of the imaging) and make sure to follow up looking for those results to update the discharges as soon as possible.

CLIENT INSTRUCTIONS:

This section should be easy to read for the owner, so remember to use minimal veterinary jargon. Do *not* copy and paste the referring report into this section. Write a short and simple explanation of a disease and/or an explanation for why we are performing certain tests or treatments. Use this section mostly to let the owner know what to do in terms of home care (feeding, restrictions, medications, other treatments), and what to watch for. It is also the place to describe what to expect. For example, if the patient had sedation or

anesthesia, write that he might be a little groggy and to hold on food and water. Below is an example of the type of information and the level of detail to include in this section.

Example for the Client Instructions section:

COUGH

You brought Sammy to be evaluated by the Internal Medicine Service today because you were concerned about his cough. Today, we performed tests that have helped us narrow down the possible causes of Sammy's cough. Some of the results of these tests are still pending, and we do not want to initiate specific therapy until we have these results. However in the meantime we are starting to treat Sammy's cough with a cough suppressant. Give the medication as described above and watch for signs of sedation. Please call us if you feel this medication does not improve his cough or if he appears overly sedate. We will call you with the results of the pending tests once they are in hand, and at that time we will recommend a plan for therapy +/- additional testing that may be indicated for Sammy's cough.

ANEMIA/INTESTINAL BLEEDING

We performed some basic labwork today to evaluate Sammy's systemic health. We found that he has some changes in his red blood cells – they are mildly decreased in number (anemia). We see that his bone marrow is making an effort to produce more blood cells, but we are worried that Sammy may have some intestinal bleeding that is causing his anemia. Sammy has a history of aspirin administration, which is a drug that can increase the risk of intestinal bleeding. In addition, there is a small amount of digested blood present in his stool (dark, tarry appearance) on rectal examination. At this time, we recommend discontinuing the aspirin therapy until otherwise directed. In addition, we have prescribed some gastro-protectant medications to help treat intestinal ulcerations. Watch Sammy for signs of weakness, pale gums, increased breathing rate and effort (signs of worsening anemia), and monitor his stools for continued presence of melena (dark and tarry in appearance). Call if you note any of these signs. We would like to recheck Sammy's red blood cell count in one week.

PLAN

1. Give cough suppressant as directed.
2. We will call you with the results of the pending tests.
3. Discontinue aspirin.
4. Start GI protectant medications.
5. Monitor for signs of anemia and continued GI bleeding.
6. Schedule recheck of anemia in 1 week, sooner if needed.

REFERRAL REPORT:

This section should be complete, but as succinct as possible. The referral report should use professional language (i.e. radiographs instead of x-ray). Make sure to refer to the referring veterinarian as Dr. _____, rather than “the rDVM”, it is more respectful. The key is to summarize the case with the important details so the referring veterinarian can follow the case without sorting through extraneous information. The general format to follow includes the following:

HISTORY: starts signalment and chief complaint, followed by a summary of events leading up to presentation, including relevant findings from the referring veterinarian and any past medical history that may be significant in light of the current problem.

PHYSICAL EXAM: Write out your physical exam, summarized in the order that you would write it as part of your SOAP but in full sentences.

DIAGNOSTICS: include the problems identified for the patient, major rule-outs, and the tests performed. Results of tests are listed above and do not need to be repeated in this section, refer to them with “(see results above)” following your list of tests performed.

PLAN: This section should state our top differentials and recommendations to achieve a diagnosis, to monitor the patient, and to treat the patient.

A final statement should be written thanking the referring vet for the referral, stating that we will call with pending results, and indicating that they should call with any questions.

**A few notes about discharges for inpatients:

- Make sure the discharge day is correctly entered in the initial section.
- Medications listed include only those that the animal is going home on, you do NOT need to list all the medications received in hospital.
- The referral report format changes slightly.
 - Diagnostics section – should include initial testing, but other tests performed during hospitalization will be mentioned in the summary of the patient’s stay
 - Plan section – replaced by an “Initial Plan section” to summarize how we stabilized or started to treat the patient. We then discuss changes or additions to our plan in the summary of the patient’s stay.
 - Summary section – additional section to summarize the patient’s stay, without extraneous details. Major changes in the patient’s condition, additional testing, general changes to therapy, and recommendations for at home treatment and monitoring should be included.

A few last final hints:

- Start inpatient discharges early, and update them daily with results and summary of the day’s events. These summaries will likely be edited right before discharge to summarize only pertinent information, but it will save you a lot of time.
- Read over your own discharges and correct your own grammar! Keep your writing simple, it will shorten the report without losing any information.
- Spell check your report before having us read it!
- Make sure we are giving you proper feedback on your discharges, it will help you improve your writing skills!