REHABILITATION DISCHARGE SUMMARY

Patient Name: Smith, Jonathan
DOB: 28-August-1933, 82 years old
MRN: 1234567
Gender: Male

VISIT ENCOUNTER

Visit Number: 11186424686
Admission Date: 07-Aug-2015
Discharge Date: 22-Sept-2015
Discharge Diagnosis: Traumatic Brain Injury

Ensure Primary Care / Referring Provider information is correct

Primary Care Provider / Family Physician: Jay, Samantha; 416-555-5555
Most Responsible Health Care Provider: Snow, Michael; Physician; 416-123-4567
Discharge Summary Completed by: Bee, Laura; Resident; 416-321-4567 **on** 23-Jul-2015

Patient Encounter Type: Inpatient
Discharge Disposition: Discharged to home or setting with support services **from** Toronto Rehabilitation

DIAGNOSIS (Co-Morbidities and Risks)

Be concise and itemize descriptions of patient's initial presentation

Conditions Impacting Hospital LOS:

Pre-Existing:

1. Sternal fracture and consequent retrosternal hematoma: The patient was admitted to Toronto Rehab for neurophysical rehab from Sunnybrook following a motor vehicle accident which occurred on July 4, 2015.
2. Small subarachnoid hemorrhage
3. Left rib fractures

Indicate pre-existing conditions patient arrived with vs. conditions that developed during stay

Conditions Not Impacting LOS:

1. Type 2 diabetes: Was under reasonable control. His hemoglobin ALC was 0.062 on admission. His oral agents were continued, initially his GLICLAZIDE MR was decreased to 30, but sugars were not under optimal control and therefore the admission dose of 60 mg of GLICLAZIDE MR was reinstituted. Fasting blood sugars range between 6 and 8.
2. Coronary artery disease
3. Cirrhotic liver disease: Mr. Smith was maintained on SPIRONOLACTONE, as well as FUROSEMIDE. He also was on twice daily dosing of LACTULOSE to maintain a minimum of 2 bowel movements per day. He has a p.r.n. dosing of LACTULOSE at noon if this minimum number of bowel movements is not met. However, generally, his bowels are moving at least twice a day without the need for the extra dose of LACTULOSE.

COURSE WHILE IN HOSPITAL

Chief Complaints and Concerns:

1. Peripheral neuropathy: The patient's main complaint was that of peripheral neuropathy involving his lateral lower extremity digits. This is not a new problem and at home, he has some improvement in this peripheral neuropathy with twice daily dosing of PREGABALIN, as well as CODEINE. Initially, the PREGABALIN dose was increased upwards to try and gain better control of his painful neuropathy; however this did result in increased daytime sedation and it was not felt there was a favorable therapeutic benefit and therefore, the dose was decreased. Prior to discharge, some topical CAPSAICIN cream was started and the patient did feel that this was beneficial, and therefore at the time of discharge, he continues on CAPSACIN cream.

Include important developments while in hospital (do not be over-inclusive)

Do not exceed more than three pages!

Summary Course in Hospital (Issues Addressed):

1. Social/Functional: Mr. Smith participated in his rehab, but was not particularly goal directed and continued to have cognitive deficits. Prior to the motor vehicle accident, he and his wife lived independently and he was the caregiver to his wife. It was not felt that Mr. Smith was going to be able to return to this level of independent living, nor could he continue his caregiver role. Various options were explored with the Community Case Manager, and ultimately it was decided that the patient would be discharged to his some with maximal CCAC supports and that a long-term care application would be initiated for both the patient and his wife.
2. Appointments: The patient did have a dental appointment, as well as optometry follow-up (new refraction prescription obtained)
3. Discharge: Having completed his rehab, the patient was discharge to home with CCAC in place but awaiting long-term care placement. The patient will have ongoing PT, OT services and arrange through the Private Community Team.

Investigations:

Labs

	Test	Test Date	Results	Units
1	Hemoglobin	21-Sept-2015	117	g/L
2	Ferritin	21-Sept-2015	38	ng/mL
3	B12	21-Sept-2015	348	pg/mL

Only include significant or abnormal lab, radiology and diagnostic results

Interventions (Procedures & Treatments):

None

Allergies: None

DISCHARGE PLAN

Medications at Discharge:

Unchanged Medications:

- MULTIVITAMIN once daily
- VITAMIN C 500 mg daily.
- SPIRONOLACTONE 100 mg daily.
- FUROSEMIDE 40 mg daily.
- LACTULOSE 30 mL b.i.d. (an additional p.r.n dose of 30 at noon if the patient does not have two bowel movements per 24 hours).

Categorized listing of medications

Adjusted Medications:

- BISOPROLOL 5mg oral once daily.
- ATORVASTATIN 40 mh at h.s.
- RABEPRAZOLE 20 mg daily.
- METFORMIN 1000 mg b.i.d. (with lunch and supper)
- SITAGLIPTIN 50 mg b.i.d. (with lunch and supper)
- GLICLAZIDE MR 60 mg daily.
- VIATMIN B12 1200 mcg daily.
- FERROUS FUMARATE 300 mg daily.
- ACETOMINOPHEN 650 mg q. 8h.
- MELATONIN 6 mg sublingual at h.s.
- PREGABALIN 100 mg at h.s. and PREGABALIN 50 mg q.a.m.

Printed by: White, Mike on 29-SEP-2015

- HYDROMORPHONE 1 mg q. 6h. p.r.n. (patient taking HYDROMORPHONE only occasionally once to twice per week overnight for neuropathic foot pain)

New Medications:

- CAPSAICIN 0.075 percent q.i.d. (to be applied bilaterally to the lateral 3 toes of both feet)

Medications on Hold:

- ECASA 81 mg daily (on hold, pending GI consult)

Itemized follow-up plan instructions for patient, and recommendations for Provider(s)

Follow-Up Plan Recommended for Receiving Providers:

1. ECASA: It should be noted that the patient's ASA had not been restarted, which he is on for secondary cardiac prevention, pending Neurotrauma and GI follow-up at Sunnybrook Hospital.
2. Following Endoscopy Appointment with Dr. Cairn: I ask that following Dr. Cairn's Oct. 8 endoscopy appointment (assessing for esophageal varices) that if Dr. Cairn agrees with resumption of ECASA that he inform Mr. Smith, and also note it in his clinic note so the family doctor will be aware.

Referrals and Appointments:

	Appointment With	**Location / Time**	**Comments/Instructions**
CLINIC WILL CONTACT PATIENT	Neurotrauma Clinic (Dr. Kenneth Cole) 416-340-4555	Sunnybrook Hospital October 2015	The clinic will contact the patient/patients caregiver to schedule an appointment
BOOKED	GI Clinic (Dr. Cairn) 416-333-3333	Sunnybrook Hospital October 8, 2015 9:00am	
BOOKED	Psychiatry Clinic (Dr. Brown) 416-111-2222	Toronto Rehab Tuesday, October 18, 2015	Patient to return to TRI for follow-up with Dr. Brown in the out-patient Psychiatry Clinic

Follow-up arrangements and referrals listed as scheduled / to be scheduled or booked

Copies to be sent to:

1. Jay, Samantha; Family Physician; 416-555-5555
2. Dr. Kenneth Cole; Neurologist; 416-340-4556
3. Dr. Cairn; Internist; 416-333-3344

Contributor of this Sample Discharge Summary: *Dr. Laurel Bates, Physician, Acquired Brain Injury Rehab, 2016.*