

3 The Immediate Discharge Document

Item	Field	Notes
	Items shown in bold are essential Items not in bold are desirable	
1 Hospital	Text field	*
2 Patient ID	<ul style="list-style-type: none"> ■ national id number ■ local id number ■ title ■ first forename ■ preferred forename ■ surname ■ address 1 ■ address 2 ■ address 3 ■ address 4 ■ postcode ■ date of birth ■ occupation 	CHI is recommended *
3 Preferred GP ID	<ul style="list-style-type: none"> ■ forename ■ surname ■ address ■ address 1 ■ address 2 ■ address 3 ■ address 4 ■ postcode 	The minimum dataset requires that the discharge summary is sent to the preferred GP. In the absence of a preferred GP it should be sent to the GP with whom the patient is registered. Multiple copies of this document may be required, eg patients not returning to their own home immediately.
4 Consultant ID	<ul style="list-style-type: none"> ■ forename ■ surname ■ specialty 	An immediate discharge document should be produced after each significant episode, eg moving from a surgical to a general ward.
5 Ward/Department	text	The ward or department issuing the IDD should be specified.
6 Date of admission/transfer	date	To the unit issuing IDD. This may be a transfer from another unit.
7a Date of discharge/transfer	date	From the unit issuing the IDD. This will include transfer to another unit. 7a & 7b are mutually exclusive.
7b Date of death	date	7a & 7b are mutually exclusive.
8 Reason for admission/transfer	<ul style="list-style-type: none"> ■ text ■ code 	<ul style="list-style-type: none"> ■ Description of complaint or reason for admission ■ This may be coded.
9 Mode of admission	choice	Elective, emergency or transfer.
10 Source of admission	text	Source of referral for this admission.
11 Diagnosis/problems (multiple)	<ul style="list-style-type: none"> ■ text ■ code(s) ■ provisional/confirmed 	<ul style="list-style-type: none"> ■ Text description should be given for each significant condition ■ The diagnosis should be described ■ When possible standard code(s) should be provided ■ It should be made clear whether the diagnosis is provisional or confirmed.
12 Significant operations/procedures (multiple)	<ul style="list-style-type: none"> ■ text ■ code(s) ■ date of procedure 	<ul style="list-style-type: none"> ■ Operations/procedures (eg chemotherapy) should be described ■ When possible standard code(s) should be provided ■ Named consultant not required if IDD issued after each significant episode or event as already given in field 4.
13 Relevant investigations	<ul style="list-style-type: none"> ■ text ■ code(s) 	<ul style="list-style-type: none"> ■ Relevant investigations performed should be described ■ Standard codes optional.
14 Complications (multiple)	<ul style="list-style-type: none"> ■ text ■ code(s) 	<ul style="list-style-type: none"> ■ Complications should be described (medical and/or surgical) ■ When possible standard code(s) should be provided.

Item	Field	Notes
15 Medication on discharge (multiple fields as required)	<ul style="list-style-type: none"> ■ name of drug (generic where possible) ■ formulation ■ current dose ■ dose changed ■ drug stopped ■ new prescription ■ route of administration ■ frequency ■ length of treatment ■ supply given to patient ■ start and stop dates (where relevant) ■ reasons for starting and stopping (where relevant) ■ compliance aids Y/N/text 	<ul style="list-style-type: none"> ■ The minimum dataset is not a discharge prescription, however a full prescription history is advised unless the IDD follows an episode that does not result in a change to long term medication ■ Start and stop dates for short or defined courses of treatment should be detailed ■ Details of whether compliance aids are required or already given to the patient should be provided. If already provided, detail whether being used or not.
16 Adverse reactions	Text	Include all known allergies
17 Discharge plans	<ul style="list-style-type: none"> ■ destination - text ■ review at hospital Y/N ■ mobility / disability (see below) ■ care arrangements made Y/N ■ care arrangements - text ■ information to patient? Y/N/text ■ information to carer or relative? Y/N/text ■ early GP review recommended? Y/N/text 	<ul style="list-style-type: none"> ■ Further information eg destination to care home ■ Comment on whether hospital review required ■ Review date and by whom ■ Care arrangements made - this will vary greatly according to patient type eg district nurse/social worker /carer for elderly patients, none for others. Other agencies involved and eligibility for higher or lower free care should be noted ■ Information to patient, include whether written or verbal or both. If yes, explanatory text required ■ Information to carer or relative, include whether written or verbal or both ■ If early GP review recommended, explanatory text required.
18 Information to patient and/or carer/relative	<ul style="list-style-type: none"> ■ Y/N ■ sickness certification issued Y/N/NA 	If sickness certification issued state duration. ²⁹
19 Comment	free text to amplify minimum data	Optional - not required for straightforward admissions
20 Results awaited	Y/N (If Y specify)	eg pathology, investigations, imaging
21 Letter to follow	Y/N	
22 Contact	<ul style="list-style-type: none"> ■ Telephone number 	The minimum information required is an appropriate contact telephone number - to be decided locally.
23 Signature & name & rank/position	<ul style="list-style-type: none"> ■ Signature ■ Legible text of name ■ Job Title 	To be completed by the responsible person at the time of discharge eg resident, sister, senior nurse or senior medical staff. They are signing on behalf of the person named in field 4 who is responsible for the document.

**In an electronic system these data should be downloaded from a Patient Administration System (PAS) file*

Disability Scale <i>adapted from Rankin Scale³⁰</i>	Mobility Scale <i>adapted from Royal College of Physicians National Sentinel Audit³¹</i>
0 = well, no symptoms	0 = bedridden or wheelchair bound
1 = minor symptoms not affecting lifestyle	1 = sits without support
2 = minor handicap but independent in self care	2 = walks with help of another person
3 = moderate handicap but needing a little help with activities of daily living (ADL)	3 = walks with aid
4 = needing a lot of help with ADL	4 = walks 5 metres without aids
5 = needing constant attention day and night	5 = able to walk 200 metres outside