Scenario

Discharge Care Letter

Scenario
Scenario here.

Assume it is **TODAY** and it is **00:00**.
This documentation is for your use and is **not marked** by the examiners.

This will be prefilled for your information on the day of the examination.

Discharge Care Letter

<table>
<tr><td>Patient Details:
Name:
Hospital Number:
NHS Number:
Date of Birth:
Address:</td><td>Next of Kin Details:

Name, Relationship
Contact Number</td></tr>
<tr><td colspan="2">Patient GP:
Name
Address</td></tr>
<tr><td colspan="2">What was the main reason for admission?</td></tr>
<tr><td colspan="2">Date of admission:</td></tr>
<tr><td colspan="2">Primary Diagnosis</td></tr>
<tr><td colspan="2">Actual and/or potential nursing care needs/problems/activities of daily living identified during patient stay.</td></tr>
<tr><td colspan="2">Nursing/Medical Interventions</td></tr>
<tr><td colspan="2">Past Medical History</td></tr>
<tr><td colspan="2">Medications</td></tr>
</table>

New Medications added this admission:
Allergies
Social History
Discharge Summary
Name (print):
Nurse Signature:
Date: Yesterday
Date and time of transfer: Yesterday, 00:00