Discharge Letter Example 1

***Letter Date**: xx/xx/xxxx*
Reference:
***Dictated Date:** xx/xx/xxxx*
***Transcribed Date:** xx/xx/xxxx*
PATIENT; ……D.O.B:……..; CHI: …….

***Admission:** Specialty -….; Ward – xx*
***Consultant:** Date of Admission - xx/xx/xxxx*
***Date of Discharge** - xx/xx/xxxx; **Discharged to:** [. .]**Follow Up:** [ ]*

Clinical Comments:
Diagnosis: Musculoskeletal chest pain
Ischaemic heart disease
Type II diabetes mellitus
Hypertension
Previous CVA
Obesity
This [..] year old woman was admitted with a complaint of recurrent [chest pain]. There is a background of ischaemic heart disease with previous [. .] myocardial infarction and [. . .]
Other history is of hypertension, cerebral vascular disease, type II diabetes mellitus and obesity. Cardiac examination [. .] ECG showed sinus rhythm with old [. .] infarction. There were no sequential changes and troponin was not raised.
I felt that her symptoms were consistent with musculoskeletal origin. [. .].

Yours sincerely,

Dr [. .]

INFORMATION COMMENTS FOR CODING PURPOSES:

This is a good example of a very codeable discharge summary with a good patient history identifying any relevant co-morbidities

Discharge Letter Example 2

***Letter Date**: xx/xx/xxxx*
Reference:
***Dictated Date:** xx/xx/xxxx*
***Transcribed Date:** xx/xx/xxxx*
PATIENT; ……D.O.B:……..; CHI: …….

***Admission:** Specialty -Opthalmology Ward – xx*
***Consultant:** Date of Admission - xx/xx/xxxx*
***Date of Discharge** - xx/xx/xxxx; **Discharged to:** [. .]**Follow Up:** [ ]*

Clinical Comments:

Procedures – Insertion of prosthetic replacement of lens NEC
Phakoemulsification of lens

Clinical Comments:

Diagnosis:

Cataracts

Diabetes

[. .]

Treatment: Right phaco and IOL under local anaesthesia

Treated: xx/xx/xxxx

Yours sincerely,

Dr [. .]

INFORMATION COMMENTS FOR CODING PURPOSES:

This summary provides precise procedure information made available for coding purposes. It is worth pointing out that there are codes available to specifically code diabetic cataracts however a coder will not assume that the cataracts are due to diabetes unless a clinician specifically states diabetic cataracts in the clinical information. In this example therefore you would not code diabetic cataracts as there is nothing in the information to state that the association is causal even though the patient has diabetes.

Discharge Letter Example 3

***Letter Date**: xx/xx/xxxx*
Reference:
***Dictated Date:** xx/xx/xxxx*
***Transcribed Date:** xx/xx/xxxx*
PATIENT; ……D.O.B:……..; CHI: …….

***Admission:** Specialty -….; Ward – xx*
***Consultant:** Date of Admission - xx/xx/xxxx*
***Date of Discharge** - xx/xx/xxxx; **Discharged to:** [. .]**Follow Up:** [ ]*

Diagnosis: Syncope and collapse

Follow Up: [ ]

Clinical Comments:
Diagnosis: 1. Likely vasovagal episode 2 . Type II diabetes mellitus 5. Minor atelectasis of [. .] 6. Incidental [. .] 7. Macular degeneration 8. CKD

Medications on discharge: As per the immediate discharge summary

I saw this [. .] year old lady on the day of admission who came in with a history of blackout [. .]. She had a background of type II diabetes mellitus. There was no [. .]. Her 12 lead ECG showed [. .]. She had a negative troponin after admission. Her D dimer was [. .]. She underwent a CTPA which did not show any clot however there was some suggestion of atelectasis [. .]. Yours sincerely,

Yours sincerely,

Dr [. .]

INFORMATION COMMENTS FOR CODING PURPOSES:

Appears to be a good summary with lots of information on comorbidites and other additional findings included. However from a coding perspective there is a bit of conflicting information. Coders would not normally code anything which began with ‘suggestion of’. In this case the information was also included in the diagnosis and so it would be reasonable to code. The term ‘likely’ was also used. In this case we would also code as present.

Discharge Letter Example 4

***Letter Date**: xx/xx/xxxx*
Reference:
***Dictated Date:** xx/xx/xxxx*
***Transcribed Date:** xx/xx/xxxx*
PATIENT; ……D.O.B:……..; CHI: …….

***Admission:** Specialty -Orthopaedics….; Ward – xx*
***Consultant:** Date of Admission - xx/xx/xxxx*
***Date of Discharge** - xx/xx/xxxx; **Discharged to:** [. .]**Follow Up:** [ ]*

Diagnosis Site Side
Primary arthritis of joint, specify (ICD10: M19.0) Knee Right

Long Term Conditions: Primary arthritis of joint, specify

Date Procedures/Interventions/Operations
xx/xx/xxxx PRIMARY TOTAL PROSTHETIC REPLACEMENT OF KNEE JOINT NEC

Clinical Comments:
This [. .] year old gentleman underwent right total knee joint replacement under Mr [. .]. No complications post-op or intra-operatively. NV intact. Obs stable, fit for discharge.

Treatments: None recorded.
Follow-up arranged: [ ]
Planned Outpatient
Investigations:

Yours sincerely,

Dr [. .]

INFORMATION COMMENTS FOR CODING PURPOSES:

In this example the diagnosis description in the text and ICD10 code provided by the clinician are not consistent (the code description for M19.0 is Primary arthrosis of other joints) – the text stating right knee has been added on as supplementary information. There is a specific code available for knee arthritis (M17). The 'Primary arthritis of the joint' description provided does not specify whether the arthritis is osteoarthritis or rheumatoid arthritis although the addition of information about it being 'primary' is useful and can be coded. If further detail had been provided in the summary as to whether the joint was cemented, uncemented or hybrid the coder could have also included this additional level of detail.

Discharge Letter Example 5

***Letter Date**: xx/xx/xxxx*
Reference:
***Dictated Date:** xx/xx/xxxx*
***Transcribed Date:** xx/xx/xxxx*
PATIENT; ……D.O.B:……..; CHI: ……

***Admission:** Specialty -Orthopaedics….; Ward – xx*
***Consultant:** Date of Admission - xx/xx/xxxx*
***Date of Discharge** - xx/xx/xxxx; **Discharged to:** [. .]**Follow Up:** [ ]*

Clinical Comments: Ms [. .] was admitted under Mr [. .] after sustaining an injury to her left index finger. No fracture was seen on xray.

Yours sincerely,

Dr [. .]

INFORMATION COMMENTS FOR CODING PURPOSES:

In this example there is no information about the type of injury or how it happened. This patient actually had an open would (laceration) with injury to the tendon (as verified at a later clinic appontment). There was also a repair procedure carried out at that time but this was not included in the discharge summary and would not be captured in national statistics. From an injury prevention perspective it would also have been useful to know how the injury had been sustained so that this information could be coded

Discharge Letter Example 6

***Letter Date**: xx/xx/xxxx*
Reference:
***Dictated Date:** xx/xx/xxxx*
***Transcribed Date:** xx/xx/xxxx*
PATIENT; ……D.O.B:……..; CHI: …….

***Admission:** Specialty - Opthalmology….; Ward – xx*
***Consultant:** Date of Admission - xx/xx/xxxx*
***Date of Discharge** - xx/xx/xxxx; **Discharged to:** [. .]**Follow Up:** [ ]*

Clinical Comments:

[. .] underwent an uncomplicated right cataract extraction under local anaesthesia on [. .]. The patient was discharged with the following medication:

Yours sincerely,

Dr [. .]

INFORMATION COMMENTS FOR CODING PURPOSES:

Not enough detail provided about the method of extraction and other operative detail e.g. lens information.

Discharge Letter Example 7

***Letter Date**: xx/xx/xxxx*
Reference:
***Dictated Date:** xx/xx/xxxx*
***Transcribed Date:** xx/xx/xxxx*
PATIENT; ……D.O.B:……..; CHI: …….

***Admission:** Specialty -Urology….; Ward – xx*
***Consultant:** Date of Admission - xx/xx/xxxx*
***Date of Discharge** - xx/xx/xxxx; **Discharged to:** [. .]**Follow Up:** [ ]*
–

Clinical Comments: This gentleman was admitted on [. .] for check cystoscopy and [. .] ureteric stent change. He is for home with relevant medications and for repeat stent change with Mr [. .]
Treatments: None recorded.

Yours sincerely,

Dr [. .]

INFORMATION COMMENTS FOR CODING PURPOSES:

No diagnostic information provided.