

WESTERN HEALTH AND SOCIAL CARE TRUST
Altnagelvin Area Hospital

Discharge Date:	Discharged to:	Hospital No. / HCN: * «PTNHSI I» *
	Please Select:	«ADMCNOTE_EXT» / «PTCSA»

GP: Dr «Ptgpname» «Ptgp_Ad1» «Ptgp_Ad2» «Ptgp_Ad3» «PTGP_PCODE»	Patient Details: «Ptfnames» «Ptsname» «Pt_Ad1» «Pt_Ad2» «Pt_Ad3» «PT_PCODE» Tel no. «PT_HTEL» DOB: «PTDOB»
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Dear Dr «Ptgpname»

The above-mentioned patient was admitted to Altnagelvin Hospital from Please select: on the «ADMDTIME», «ADMNNAME» under the care of «ADMCONFP» «ADMCONNAME».

Primary Diagnoses:

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Secondary Diagnoses:

1.		2.	
3.		4.	
5.		6.	

Primary Procedures (incl. dates):

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Secondary Procedures:

Relevant Investigations:

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Outstanding Investigations:

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Information (incl. diagnosis) given to:

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Blood products/Components Used (include details and reasons for transfusion, adverse events, eligibility to donate blood):

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Doctor's Comments:

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Hospital follow-up required: No *(if yes, please provide details)*

Clinic:		Weeks:	
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Doctor's Signature:

Date:

cc.

DRAFT VERSION produced by **FY1** Further letter to follow: Y N

Prescriber's Designation:		Clinical Check/Date:	
Prescriber's Name:		Labelled by:	
Prescriber's Signature:		Dispensed by/Date:	
Date:		Final Check:	

This patient may be suitable for repeat dispensing? Not applicable

Completed and Verified by:
Consultant's Signature:

NAME IN BLOCK CAPITALS:

DISCHARGE CONTROLLED DRUGS
DATE ISSUED: _____
ISSUED BY SIGNED: _____
DELIVERED BY SIGNED: _____
PRINT NAME: _____
RECEIVED BY SIGNED: _____

DISCHARGE CONTROLLED DRUGS
DATE: _____
ISSUED TO PATIENT BY: _____
PATIENT/CARER SIGNATURE: _____