ส่วนที่ 2 (Form B) Physician Discharge Summary

กรุณาเขียนด้วยตัวบรรจง

ถึง		จาก	โรงพยาบาล หมายเลขโทรสาร……………….……ห้อง ……..………..

Patient's Name: …………………………………………………………………………HN…………………………………AN………..……………

Admission Date ……………………………Time……………………….Discharge Date …………………………… Time ………………………...

Please give detail relating to this treatment ***Please use medical terminology**

For Illness:

1. Date you first saw this patient for this illness: ……………………………………………………………………………………………………..
2. Chief complaint and duration of symptoms: ………………………………………………………………………………………………………
3. In your opinion, how long should this symptoms persist for this illness: ……………………………………………………………

For Injury:

1. Date & Time of injury …………………………………..Date & Time you first saw this patient……………………………….…….
2. Cause of injury ……..

Nature of wound and injured organs………

มีเอกสารแนบ ……

3. (Did you smell alcohol from the patient?)

ได้กลิ่นสุราจากผู้ป่วยหรือไม่ ( ) No ( ) Yes ( ) Not known

Level of consciousness ( ) Normal ( ) Confusion ( ) Drowsiness ( ) Semi-coma ( ) Coma

(Did the patient take any medication, drugs?)

ผู้ป่วยกินยามาหรือไม่ ( ) No ( ) Yes (ชื่อ/ชนิด ของยา) …………………………………….. ( ) Not known

Pertinent Clinical findings (Symptoms & Signs)……………………………………………………………………………………………

………..

Underlying diseases……

Investigations/ Pathological studies………………………………………………………………………………………………………

………..

Diagnosis 1. ……………………………………………………………………………………………………….…ICD10-TM ……………..

Diagnosis 2…………………………………………………………………………………………...………… ICD10-TM ……………..

Diagnosis 3……………………………………………………………………………………………...…… ICD10-TM…….……….

(Please fill the diagnosis that has been treated on this admission, not including the underlying diseases or conditions not treated: please rank from the most important Dx to the least one)

Treatment……..………

……

Surgery/Operation…..…………………………………………………………………….Date…………………..ICD10-TM/ICD9-CM..……………...

Result /Complications………

Is the illness related to alcohol, drug abuse or addiction? ( ) No ( ) Yes ( ) Not known

For Female is the patient pregnant? ( ) No ( ) Yes Gestational age……………Wks

Was the treatment related to infertility? ( ) No ( ) Yes…………………………………

HIV ( ) Not done ( ) Done ( ) Result ……………………… (ในกรณีที่ผู้ป่วยยินยอมให้เปิดเผย :ลายเซ็นต์ ....)

Has patient ever been treated by other doctor before? ( ) No ( ) Yes, please give name and address………………………………

Past History

Date	Signs & Symptoms	Diagnosis	Treatment	Physicians

For accident: estimated time for recovery………………………………………………………………………………………

Signature………………………………………… Medical specialty………………………………Medical License No…………..

(…………………………………….) Tel. No. ………………………………………Date………………………………….