

Progress Note	<p><u>Progress Notes</u> - Progress notes should be electronically created with a frequency that reflects appropriate attending involvement but at least every day. For rehabilitation admissions a physician progress note must be documented by the responsible physician a minimum of every 5 days. Exceptions may be given to an obstetrical patient that has a discharge order entered from the day before or for a patient admitted to a psychiatric unit. Progress notes should describe not only the patient's condition, but also include response to therapy.</p>
Admitting Note	<p>Admitting Note- The responsible provider must see the patient and document an admitting note (that justifies admission and determines the plan of treatment) within 24 hours of admission.</p>
Consultation Reports	<p><u>Consultation Reports</u> - A satisfactory consultation includes examination of the patient as well as the medical record and should be electronically recorded or dictated within 24 hours. When operative procedures are involved, the consultation shall be recorded prior to the operation (except in an emergency).</p>

Discharge Documentation	<p>A discharge summary must be documented at the time of discharge but no later than 7 days thereafter by the responsible practitioner on all Inpatient and Observation hospitalizations 48 hours or greater in length. Normal newborns and normal vaginal deliveries do not require a discharge summary regardless of the length of stay.</p> <p>Reason for hospitalization</p> <p>Concise summary of diagnoses including any complications or co-morbidity factors</p> <p>Hospital course, including significant findings</p> <p>Procedures performed and treatment rendered</p> <p>Patient's condition on discharge (describing limitations)</p> <p>Patients/Family instructions for continued care and/or follow-up</p>
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The final discharge progress note should be documented immediately upon discharge for inpatient stays less than 48 hours, observations, extended recovery, normal newborns and normal vaginal delivery cases. The note shall include:

- Final diagnosis(es)
- Condition of patient
- Discharge instructions
- Follow-up care required