SUMMARY OF HOSPITALIZATION

PATIENT'S NAME: _____

SSN (or DBN): _____ DOB: _____

AGENCY: _____ POST: _____

ADMISSION DATE: _____ DISCHARGE DATE: _____

HOSPITAL NAME: _____

HOSPITAL ADDRESS: _____

HOSPITAL TELEPHONE: _____

ATTENDING PHYSICIAN: _____

Presenting Problem:

Past History:

System Review:

Physical Findings:

Lab Service and Radiological Findings:

Surgical Procedures:

Time and Date of Anesthesia Services:

Diagnosis:

Medicine:

Recommendation:

_____

Name of Physician