

EPR Core and Clinical Documentation Foundation Discharge Summary Report

Reference Guide

This **Reference Guide** explains how the **Discharge Summary Report** is automatically generated within the **Electronic Patient Record (EPR)** and the information included in this report.

The **Discharge Summary Report** is an auto-generated report that is automatically faxed to the patient's Primary Care Provider (PCP), and any additional providers listed once the patient visit has been discharged and the **Discharge Summary Note** has been completed and finalized.

The report consolidates information from two **EPR** documents

- Discharge Summary Note
- Discharge Summary Note-Supplemental (where applicable)

A copy of the full report or a subset titled **Patient Discharge Instructions** may be printed and provided to the patient.

Auto-Fax and Addendum Behavior

The **Discharge Summary Report** is generated when the **Discharge Summary Note** is finalized.

- Any addendum added to either:
 - Discharge Summary Note, or
 - Discharge Summary Note-Supplementalwill trigger the report to auto-fax again.

Note: Only Physicians can add addendums to the Discharge Summary Note.

- The updated fax includes:
 - Previously documented information
 - Newly added addendums

Provider Responsibilities

To generate the **Discharge Summary Report**:

1. Complete all required sections in the **Discharge Summary Note**
2. Complete the **Summary of Diagnosis**
3. Complete the **Completion Section**
 - Completion Section options:
 - Discharge Summary Note is complete
 - Adds the status of "**Final**" to the Discharge Summary Report.
 - Partial Discharge Summary Note. Dictation to follow.
 - Adds the status of "**Partial**" to the Discharge Summary Report.

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Note: Only the **Attending Provider** may finalize the **Discharge Summary Note**. All other providers must save as Incomplete.

Discharge Summary Report Content and Source

Section	Sub-Section	Source	Notes
Admission and Discharge Date / Time		Discharge Summary Note	<ul style="list-style-type: none"> Auto-populates the admission date. The provider selects discharge date
Neonatal Intensive Care (NICU) Admission		Discharge Summary Note	<ul style="list-style-type: none"> If there was a NICU Admission for the newborn it is selected
Disposition	Disposition	Discharge Summary Note	
Admission Findings	Admission Findings	Discharge Summary Note	Details of the significant findings can be documented
Summary of Diagnosis	<ul style="list-style-type: none"> Main Clinical Reason Other Clinical Conditions and Illnesses In Hospital Events Secondary Conditions Interventions 	Discharge Summary Note	<ul style="list-style-type: none"> Attending Provider will document primary diagnosis and other health issues for the patient. Health Issues that have already been documented will automatically flow into this section.
Course in the Hospital	Course in the Hospital	Discharge Summary Note	This section details specific details and events that occurred during the hospital admission
Labs	<ul style="list-style-type: none"> Lab Results Lab – Pending / Additional Information 	Discharge Summary Note	<ul style="list-style-type: none"> Only the results that have been selected appear in the Discharge note.

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Section	Sub-Section	Source	Notes
			<ul style="list-style-type: none"> Also, allows to free-text additional information regarding any pending labs.
Diagnostic Imaging	Diagnostic Imaging Reports – Comments	Discharge Summary Note	This is a free text box that the providers can summarize the patient's radiology results
Investigation Results	Relevant Investigation	Discharge Summary Note	This is a free text box that the providers can summarize the patient's investigation results.
Consults	Summary of Consultant Notes	Discharge Summary Note	This section provides a free-text Summary of Consultant Notes field.
Vital Signs and Measurements	Vital Signs and Measurements	<ul style="list-style-type: none"> Vital Signs Flowsheet Manually Entered 	<ul style="list-style-type: none"> Prior to Discharge: from Vital Sign Flowsheet it can be entered by selecting "Retrieve Last Charted Values" <u>or</u> can be manually entered.
Allergies	Allergies	Allergy Summary	
Advance Care Plan	Advance Care Plan	Health Issues Manager	
Health Care Directive	Health Care Directive	Health Issues Manager	
Discharge Instructions	<ul style="list-style-type: none"> Medication Patient Instructions 	<ul style="list-style-type: none"> Discharge Summary Note Discharge Summary Note-Supplemental 	<ul style="list-style-type: none"> Medications: This section allows the provider to enter the details of immunizations, medications ordered or modified, and any prescriptions given. Patient Instructions: are completed by

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Section	Sub-Section	Source	Notes
			nursing in the Discharge Summary Note- Supplemental
Recommendations	<ul style="list-style-type: none"> Recommend that you see your Primary Care Provider in: Recommendations 	Discharge Summary Note	This section is where a patient recommendation for being seen by the primary care provider is entered.
Follow-Up Appointments	<ul style="list-style-type: none"> Appointment(s)- Arranged by the Unit Appointment(s)-Not Yet Arranged Appointment(s)- The following referrals have been sent. Their office should contact you 	<ul style="list-style-type: none"> Discharge Summary Note Discharge Summary Note- Supplemental 	Appointments and Referral can be entered on either document or retrieved if not present on the document at the time of completion.
Health Care Team	<ul style="list-style-type: none"> Problems During this Visit Notes 	<ul style="list-style-type: none"> Discharge Summary Note Discharge Summary Note- Supplemental 	<ul style="list-style-type: none"> Consultants document their findings and recommendations related to the patient's health issues in this section. Previously documented Health Issues auto-populate here.
Completion of Discharge Summary Note	Copies to	Discharge Summary Note	<ul style="list-style-type: none"> Completion of this section must only be performed by the Attending Provider to finalize the document. All other users must select Incomplete when saving the document.

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Section	Sub-Section	Source	Notes
Newborn History and Physical	<ul style="list-style-type: none"> • Patient Visit <ul style="list-style-type: none"> ○ General ○ Neonatal Intensive Care Unit (NICU) ○ Maternal History ○ Maternal Prenatal Labs ○ Maternal Prenatal Investigations ○ Maternal Social History ○ Antenatal Reports and Findings ○ Labour and Delivery ○ Newborn <ul style="list-style-type: none"> ▪ Apgars ▪ Umbilical Cord ▪ Vital Signs ▪ Measurements ▪ Physical Exam ▪ Impression and Plan ▪ Summary ▪ Attending Provider Comments 	History and Physical Newborn	This is pulled into the Discharge Summary Report on Newborn Deliveries, and it appears at the end of the Discharge Summary Report.
Discharge Document Addendums		<ul style="list-style-type: none"> • Discharge Summary Note • Discharge Summary Note-Supplemental 	

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Discharge Summary Report Example

	 <p>Health Sciences Centre Winnipeg A Shared Health facility</p>	Discharge Summary FINAL - Addendum added	
Test, ECR Implementation WN4-416-01 PHN: MB-123123666	36y (23-Jan-1990) Attending Provider: VCS Test User - MB, MB Reg: A12366	Female	MRN : 04000249-5 Visit: 400007436336 Series :
Address: 123 Anywhere St Test Fredericton, NB E3A 1M3		Phone: (204) 111-1111	
Admit Date / Time: 21-Feb-2026 19:07		Discharge Date / Time: 21-Feb-2026 19:26	

Final-Addendum Additional information was added to this document after it was approved by the Attending Provider. See end of document for Addendum.

Disposition:

- Home

Admission Findings:

- This information is to identify fields in the Discharge Summary Note that flows to the report. TEST

Summary of Diagnoses

Main CLINICAL REASON:

- Acute calculous cholecystitis

Other CLINICAL CONDITIONS / ILLNESSES:

- Acute calculous cholecystitis

In HOSPITAL EVENTS:

- Kidney mass

SECONDARY CONDITIONS:

- Hyperlipemia

INTERVENTIONS:

- Laparoscopic cholecystectomy using 2 mm laparoscope

Course In Hospital

Course in Hospital:

- This information is to identify fields in the Discharge Summary Note that flows to the report.

Labs

Lab - Pending / Additional Information:

- This information is to identify fields in the Discharge Summary Note that flows to the report.

Diagnostic Imaging

Diagnostic Imaging Reports - Comments:

- This information is to identify fields in the Discharge Summary Note that flows to the report.


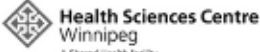
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				Discharge Summary FINAL - Addendum added											
Test, ECR Implementation WN4-416-01 PHN: MB-123123666	36y (23-Jan-1990) Attending Provider: VICS Test User - MB, MB Reg: A12366	Female	MRN: 04000249-5 Visit: 400007436336 Series:												
Investigation Results <ul style="list-style-type: none"> Relevant Investigations: This information is to identify fields in the Discharge Summary Note that flows to the report. 															
Consults <u>Summary of Consultant Notes:</u> <ul style="list-style-type: none"> This information is to identify fields in the Discharge Summary Note that flows to the report. 															
Vital Signs and Measurements <u>Vital Signs:</u> <ul style="list-style-type: none"> Temperature: 38 degrees Celsius Heart Rate: 80 beats / min Respiratory Rate: 20 breaths / min Blood Pressure: 120 / 80 															
Allergies <u>Allergies:</u> <table border="1"> <thead> <tr> <th>Category</th> <th>Allergen Type</th> <th>Allergen/Product</th> <th>Confidence Level</th> <th>Reaction</th> </tr> </thead> <tbody> <tr> <td>Allergies</td> <td>Drug</td> <td>penicillin</td> <td>Suspected</td> <td>Abdominal Pain</td> </tr> </tbody> </table>						Category	Allergen Type	Allergen/Product	Confidence Level	Reaction	Allergies	Drug	penicillin	Suspected	Abdominal Pain
Category	Allergen Type	Allergen/Product	Confidence Level	Reaction											
Allergies	Drug	penicillin	Suspected	Abdominal Pain											
Discharge Instructions <u>Medications:</u> <ul style="list-style-type: none"> Immunizations Administered During Course of Hospital Stay: This information is to identify fields in the Discharge Summary Note that flows to the report. NEWLY Prescribed Home Medications: This information is to identify fields in the Discharge Summary Note that flows to the report. Home Medications to CONTINUE: This information is to identify fields in the Discharge Summary Note that flows to the report. Home Medications to DISCONTINUE: This information is to identify fields in the Discharge Summary Note that flows to the report. Additional Medication Instructions / Titration Goals / Reasons for Changes: This information is to identify fields in the Discharge Summary Note that flows to the report. Prescriptions Given at Discharge: This information is to identify fields in the Discharge Summary Note that flows to the report. 															
Recommendations <u>Recommendations:</u> <ul style="list-style-type: none"> Recommended that you see your Primary Care Provider in 7 day(s) Recommendations: This information is to identify fields in the Discharge Summary Note that flows to the report. 															
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		Discharge Summary FINAL - Addendum added	
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FollowUp Appointments
Appointment(s) - Not Yet Arranged (See Supplemental Details section for additional information):

- Please contact the ward at 204-111-0000 on 27-Feb-2026 19:23 to receive further instructions and / or appointment information

Appointment(s) - The following referrals have been sent. Their office should contact you (See Supplemental Details section for additional information):

1. Referral:

- With: Test Clinic
- Contact Number: 123-123-1234

Health Care Team
Notes:

- Acute Pain Service. This information is to identify fields in the Discharge Summary Note that flows to the report.

Completion of Discharge Summary Note
Copies to:

- Tester-AD, MD1 EPR (Primary Care): MD, Medicine

Copies to Additional Providers:

- This information is to identify fields in the Discharge Summary Note that flows to the report.

Completion (See Supplemental Details section for additional information):

- Discharge Summary Note is complete

Discharge Summary - Electronic Signature:
VICS Test User - MB, Physician One (Signed 27-Feb-2026 14:07)

SUPPLEMENTAL DETAILS

The following information was provided by the Health Care Team in addition to what is present on the Discharge Summary.

Discharge Instructions
Patient Instructions:

- Call 911 in case of emergency
- Call Health Links-Info Santé for non-emergency health conditions and questions at 204-788-8200 in Winnipeg or toll-free 1-888-315-9257



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		Discharge Summary FINAL - Addendum added	
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Discharge Instructions

Patient Instructions:

- Notify your Physician if: bleeding; excessive diarrhea; fever; inability to tolerate liquids or food; increased irritability or sluggishness; numbness, tingling; pain not relieved by medications; persistent nausea and vomiting; swelling; unable to urinate
- Call this Provider (Name): Test, Provider at 204-111-1111 if you experience these symptoms:
- Work: may return to work
- Discharge Activity: resume normal activity
- Driving: may drive
- Discharge Diet: resume normal diet
- Fluid Restriction: This information is entered for reviewing Discharge Summary Report
- Discharge Meds Reviewed: yes
- Discharge Teaching Done: This information is entered for reviewing Discharge Summary Report.
- Instructions Reviewed With: caregiver
- Response to Teaching: questions
- Materials Provided: diagnosis specific handouts
- Additional Printed Instructions Given: This information is entered for reviewing Discharge Summary Report.
- Additional Discharge Instructions: This information is entered for reviewing Discharge Summary Report

Followup Appointment(s)

Appointment(s) - Arranged By Unit:

1. Appointment:

- Name: Test Clinic
- Location: 123 Anywhere St
- Phone: 204-111-1111
- Date & Time: January 31, 2099

Appointment(s) - Not Yet Arranged:

- Please contact the ward at 204-111-1111 on 27-Feb-2026 14:01 to receive further instructions and / or appointment information

Appointment(s) - The Following Referrals Have Been Sent. Their Office Should Contact You:

1. Referral:

- With: Test Clinic Program
- Contact Number: 204-111-1111
- Additional Information: This is Additional Information section.

Violence Screening

Violence Screening:

- Current violence or aggression - Patient observed to be: No evidence



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	 <p>Health Sciences Centre Winnipeg A Shared Health facility</p>	Discharge Summary FINAL - Addendum added
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Violence Screening <u>Violence Screening:</u> <ul style="list-style-type: none">Current risk factors for violence or aggression - Is the patient displaying any of the following risk factors: No evidence		
ADDE NDUM(S)		
<u>VICS Test User - MB, Physician One (MD)</u> (Signed Addendum 22-Feb-2026 12:21) <ul style="list-style-type: none">This information is to identify the addendum in the Discharge Summary Report.		
<u>VICS Test User - MB, Physician Two (MD)</u> (Signed Addendum 25-Feb-2026 12:02) <ul style="list-style-type: none">Test Addendum		
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