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Case Report: Discharging a complex, long-stay patient.

We present a case of a patient who was admitted to hospital in July 2008 and was discharged in May 2010. By the end of her admission, she had attended three metropolitan hospitals in Sydney and had over a thousand pages of paper notes in her medical record, and results of investigations on eMR.

The task of creating a summary of a complex, long-stay patient was assisted by: 1. periodic summaries of health information during the 22 month admission, 2. planning the summary in consultation with the patient, to gain their own perspective of their 'journey', and 3. using a review of systems template to cover the breadth of health information at an appropriate level of detail.