ID _____

Date of Review _____

Initials _____

		Score			Wgt	Final	Adjustments
Admission							
Reason for admission		0	1		2		
Focused history		0	1	2	2		
Histories	Medical	0	1		2		
	Social	0	1				
	Family	0	1				
Pre-admission medications		0	1	2	1		
Allergies	Identified	0	1		1		
	Reactions	0	1				
Findings of physical examination		0	1	2	2		
Major ancillary results		0	1	2	2		
					Section Score	/	
Hospital Course							
Treatments	Identified	0	1		2		
	Responses	0	1				
Consultants	Type	0	1		1		
	Name	0	1				
Procedures performed		0	1	2	1		
					Section Score	/	
Discharge							
Principal diagnosis		0	1		2		
Discharge condition		0	1	2	2		
Discharge medications		0	1	2	2		
Explanations for changes in medications		0	1	2	1		
Discharge instructions		0	1	2	1		
Results pending at time of discharge		0	1	2	1		
Follow-up plan		0	1	2	1		
					Section Score	/	

Appendix B: Scoring Rubric

History of present illness
- For a score of 0: HPI is missing
- For a score of 1: history given is incomplete, without information on causes for admission, treatments received prior to arrival on the service, history of symptoms and information on prior admissions or care given
- For a score of 2: information is complete and relevant to the patient's condition

Preadmission medications
- For a score of 0: list is missing
- For a score of 1: information in the list is incomplete (e.g., missing frequency, route or dosage, with no explanation of why information is absent)
- For a score of 2: information is complete, with all details required for medication reconciliation

Results of physical examination
- For a score of 0: list is missing
- For a score of 1: information in the list is incomplete (e.g., missing frequency, route or dosage, with no explanation of why information is absent)
- For a score of 2: information is complete, with all details required for medication reconciliation

Ancillary test results
- For a score of 0: list is missing
- For a score of 1: list of test results has been copied and pasted into the discharge summary without editing for relevance, formatting or interpretation, information is incomplete given the patient's stated history (e.g., EKG for chest pain) or missing standard admission test results
- For a score of 2: information is complete and relevant to the patient's condition. Where appropriate, test result changes over the course of hospitalization are described.

Discharge condition
- For a score of 0: summary gives no mention of the patient's condition on discharge
- For a score of 1: information on patient's condition is vague
- For a score of 2: information on patient's condition is specific and pertinent, especially for the provision of care post-discharge

Discharge medications
- For a score of 0: summary does not include a list of medications from discharge
- For a score of 1: information in the list is incomplete (e.g., missing frequency, route or dosage, with no explanation of why information is absent)
- For a score of 2: information is complete, with all details required for medication reconciliation

Explanation for changes in medications
- For a score of 0: changes in medication are not explained
- For a score of 1: only some of the changes in medication are explained
- For a score of 2: all differences between admission and discharge medication lists are accounted for and explained

Follow-up plan
- For a score of 0: no information on patient instructions or post-discharge care is discussed in the summary
- For a score of 1: the summary includes information on follow-up care but is incomplete, e.g. does not include specific times or dates for appointments or the names of providers to be seen
- For a score of 2: information on follow-up appointments is complete and specific