**IAT #5 - Track 1 – Discharge Summary Scenario**

**Header Data**

* Document Creation Date =
* Data Enterer =
* Author =
* Patient = Name, Race, Ethnicity, Language, Date of Birth
* Participant = (Next-of-kin), (Emergency Contact)
* Informant (Related) = (Daughter)
* Custodian =
* Information Recipient =
* Authenticator =
* Legal Authenticator =
* Providers involved in encounter:
  + Primary Physician =
  + Lab Technician =
  + Therapist =
  + Counselor =
  + …

**Required Sections**

* Allergies and Intolerances w/ Allergy Concern Act
* Problem w/ Problem Concern Act
* Medications w/ Medication Activity
* Admission Medications
* Discharge Medications
* Immunizations
* Reason for Referral w/ Patient Referral Act
* Reason for Visit
* Encounters Section w/ Encounter Diagnosis
* Social History w/ Birth Sex Observation, Smoking Status,
* Health Concerns w/ Health Concern Act
* Assessment or Assessment and Plan w/ Planned Act
* Goals w/ Goal Observation
* Results w/ Results Organizer or Results Observation
* Vital Signs w/ Vital Signs Organizer
* Procedures w/ Procedure Activity Act or Procedure Activity Observation or Procedure Activity Procedure
* Interventions w/ Intervention Act
* Medical Equipment w/ Procedure Activity Procedure
* Mental Status w/ Mental Status Observation
* Functional Status w/Functional Status
* Patient Decision Aids