SOP Template: Patient Status Summary and Primary Diagnosis Documentation

This SOP details the process for creating a **patient status summary and primary diagnosis documentation**, ensuring accurate and timely recording of the patient's current health condition, medical history, and the primary diagnosis made by healthcare professionals. The goal is to facilitate effective communication among medical staff, support clinical decision-making, and ensure continuity of care by maintaining comprehensive and standardized patient records.

1. Purpose

To outline the standardized steps for documenting a comprehensive summary of a patient's status and to record the primary diagnosis in accordance with healthcare best practices.

2. Scope

This SOP applies to all healthcare professionals who are responsible for documenting patient information in medical records across all departments.

3. Responsibilities

- **Physicians:** Prepare and approve the patient status summary and primary diagnosis.
- **Nurses:** Provide up-to-date clinical data and support documentation.
- **Medical Records Staff:** Ensure records are complete, accurate, and filed promptly.

4. Procedure

1. **Collect Patient Information:**
    - Full Name
    - Date of Birth
    - Medical Record Number
    - Date and Time of Documentation
2. **Obtain Current Health Status:**
    - Presenting symptoms and clinical findings
    - Vital signs and relevant investigation results
3. **Summarize Medical History:**
    - Past medical and surgical history
    - Relevant family and social history
    - Allergies and current medications
4. **Document Primary Diagnosis:**
    - Clearly state the main diagnosis (including codes if applicable)
    - Brief rationale supporting diagnosis
5. **Update and Review:**
    - Ensure all information is up-to-date at every shift change or significant status update
    - Have the documentation reviewed and signed by the responsible physician
6. **File Documentation:**
    - Store in the patient's medical record (electronic or paper as applicable)

5. Documentation Template

Patient Name:	_____	**Date of Birth:**	_____
Medical Record #:	_____	**Date/Time:**	_____
Current Health Status	_____		
Medical History	_____		

Allergies	_____
Medications	_____
Primary Diagnosis (and code, if applicable)	_____
Supporting Rationale	_____
Physician Signature	_____ Date: _____

6. Quality Assurance

- Regular audits of documentation completeness and accuracy.
- Feedback and training sessions for continuous improvement.

7. References

- Hospital Medical Record Policy
- Applicable national or local clinical documentation guidelines