ILOILO MISSION HOSPITAL
Mission Road, Jaro, Iloilo City
Tel. No. (63-33) 320-03-15 to 19
Fax No. (63-33) 320-03-21

DISCHARGE INSTRUCTION SHEET

Name: Faria Grayson **Age:** 9 mos **Sex:** M **Civil Status:** Ch **Address:** _____
Date of Admission: 7-17-25 **Date of Discharge:** 7-20-25 **Diagnosis:** Systemic Viral Infection with Moderate Dehydration
Disposition: ☑ May go home ☐ DAMA ☐ Transfer Hospital (Name of Hospital : _____

MEDICATIONS

MEDICATION ORDER	AM (AGA)	NOON (UGTO)	PM (HAPON)	NIGHT (GAB-I)	SPECIAL CONSIDERATION

DIET: ☐ Full ☐ Soft ☐ Low Fat ☐ Low Salt ☐ Hypoallergenic ☐ Diabetic ☐ OTF
Specifications: _____

ACTIVITIES / SPECIAL INSTRUCTIONS: _____

LABORATORIES AND DIAGNOSTICS: _____

CONSULTANT: Dr. Guintivano
CHECK UP DATE: Anytime for medical concerns **TIME:** _____
CLINIC ADDRESS: _____

☐ Photocopy Laboratories ☐ Advised Well

TRANSCRIBED BY:	INSTRUCTED BY:	RECEIVED AND UNDERSTOOD BY:	DATE & TIME
GENALYN PANGANIBAN	GENALYN PANGANIBAN	Precious Ann Faria Palayon	7-20-25
Signature over Printed Name	*Signature over Printed Name*	*Signature over Printed Name*	

Discharge Instruction Sheet | 2/4/2023| rga