

Date: [Date]

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Medical Record Number: [MRN]

1. PROCEDURE SUMMARY

Date of Surgery: [Date]

Procedure Name: [Name of Surgery]

Surgeon: [Surgeon Name]

Post-Operative Diagnosis: [Diagnosis]

2. CLINICAL STATUS AT DISCHARGE

The patient was evaluated in the post-surgical clinic on [Date]. The surgical site was inspected and found to be [Status of Wound]. The patient is stable for discharge from active surgical follow-up.

3. MEDICATIONS

The patient has been instructed to: [Continue/Stop/Modify] the following medications:

- [Medication Name] - [Dosage/Frequency]
- [Medication Name] - [Dosage/Frequency]

4. WOUND CARE AND ACTIVITY

Wound Care: [Instructions for cleaning, dressing changes, or suture removal]

Activity Restrictions: [Weight lifting limits, driving restrictions, or return to work date]

Dietary Instructions: [Specific diet or no restrictions]

5. WHEN TO CALL THE DOCTOR

Please contact the clinic or seek immediate medical attention if you experience:

- Fever over 101F (38.3C)

- Increasing redness, swelling, or foul-smelling drainage from the incision
- Uncontrolled pain
- Shortness of breath or chest pain
- Sudden swelling in legs

6. FOLLOW-UP APPOINTMENTS

Next Appointment: [Date/Time] with [Doctor/Department]

Primary Care Follow-up: [Recommended timeframe]

Provider Signature: _____

Clinic Name: [Clinic Name]

Contact Phone: [Phone Number]