Urgent Care Discharge Summary

Date: [Date of Visit]

Patient Name: [Patient First and Last Name]

Date of Birth: [DOB]

Provider Name: [Provider Name/Title]

Visit Overview

Reason for Visit: [Primary Complaint]

Diagnosis: [Final Diagnosis or Clinical Impression]

Treatment & Medications

Treatments Administered: [List of treatments or procedures performed]

New Prescriptions: [Medication Name, Dosage, Frequency]

Home Care Instructions

[Detailed instructions regarding rest, fluids, activity restrictions, and wound care]

Follow-Up Requirements

- **Follow-up with Primary Care Physician:** Within [Number] days.
- **Specialist Referral:** [Specialty Name / None]
- **Additional Testing:** [Pending Labs or Imaging]

Emergency Red Flags

Seek immediate emergency care at the nearest Hospital Emergency Room if you experience:

- Difficulty breathing or severe chest pain
- Loss of consciousness or sudden confusion
- Uncontrollable bleeding or severe allergic reaction
- Worsening symptoms despite treatment

Facility Name: [Urgent Care Center Name]

Contact Phone: [Phone Number]

Provider Signature: _____