Date: [Date of Service]

To: [Employer Name / Insurance Carrier]
Attention: Workers Compensation Department

RE: Workers Compensation Discharge Summary

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Injury: [Date]
Claim Number: [Claim #, if available]

Diagnosis:
[Insert Diagnosis/ICD-10 Code]

Treatment Provided:
The patient was evaluated and treated today for a work-related injury. Treatment included: [List procedures, medications administered, or x-rays].

Work Status:
[ ] May return to full duty with no restrictions effective: [Date]
[ ] May return to modified duty effective: [Date] with the following restrictions:
- [e.g., No lifting over 10 lbs]
- [e.g., No repetitive reaching]

[ ] Total Disability: Patient is unable to work until: [Follow-up Date]

Follow-Up Care:
The patient has been instructed to:
[ ] Follow up with [Specialist Name/Clinic] in [Number] days.
[ ] Return to this Urgent Care on [Date] for re-evaluation.

Provider Information:
[Physician Name/Signature]
[Clinic Name]
[Phone Number]