

Urgent Care Facility Name: [Insert Facility Name]

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Date of Service: [Insert Date]

Discharge Summary

The patient was evaluated at our urgent care facility today. Based on the clinical assessment, the following prescription therapy has been initiated:

Diagnosis: [Insert Diagnosis]

Prescription Details:

- **Medication Name:** [Insert Medication Name]
- **Dosage:** [Insert Dosage, e.g., 500mg]
- **Frequency:** [Insert Frequency, e.g., Twice daily]
- **Duration:** [Insert Duration, e.g., 7 days]

Instructions for Use:

[Insert specific instructions, e.g., Take with food, finish entire course, etc.]

Follow-Up Care:

Please follow up with your primary care physician in [Number] days. If symptoms worsen, or if you experience a severe allergic reaction (shortness of breath, swelling, or hives), seek emergency medical attention immediately.

Provider Name: [Insert Provider Name]

Provider Signature: _____

Contact Number: [Insert Facility Phone Number]