Facility Name: [Insert Hospital/Clinic Name]

Department: Endoscopy Unit

Date: [Insert Date]

Patient Name: [Insert Name]

Date of Birth: [Insert DOB]

Patient ID: [Insert ID Number]

Discharge Summary: Diagnostic Endoscopy

Procedure Performed: [e.g., Gastroscopy / Colonoscopy / Sigmoidoscopy]

Performing Physician: [Insert Doctor Name]

Procedure Findings

[Insert brief description of visual findings]

Interventions / Samples Taken

[ ] Biopsies taken (Results expected in [X] days)
[ ] Polyps removed
[ ] No samples taken

Immediate Post-Procedure Instructions

- **Diet:** [e.g., Resume normal diet / Clear liquids only for 24 hours]
- **Medication:** [e.g., Resume normal medications / Hold blood thinners for X days]
- **Sedation:** If you received sedation, do not drive, operate machinery, or sign legal documents for 24 hours.

Follow-Up Plan

[e.g., Return to clinic in 2 weeks / Follow up with GP / No further action required]

When to Seek Medical Attention

Contact the unit or go to the Emergency Department if you experience:

- Severe abdominal pain or bloating
- Heavy rectal bleeding or vomiting blood
- Fever or chills
- Difficulty breathing or swallowing

Unit Contact Number: [Insert Phone Number]

After Hours Emergency: [Insert Phone Number]

Signed: _____ (Physician/Nurse)