

**Date:** [Insert Date]

**Patient Name:** [Insert Patient Name]

**Date of Birth:** [Insert DOB]

**Discharge Date:** [Insert Date]

Dear [Patient Name],

This letter outlines your post-discharge treatment plan and medical directives to ensure your continued recovery. Please follow these instructions carefully.

## **1. Medication Instructions**

[List all medications, dosages, and frequencies here. Note any new prescriptions or changes to existing ones.]

## **2. Follow-Up Appointments**

- **Provider:** [Doctor Name] - **Date/Time:** [Date/Time]
- **Provider:** [Specialist Name] - **Date/Time:** [Date/Time]

## **3. Activity Restrictions and Diet**

**Physical Activity:** [e.g., No heavy lifting over 10 lbs, bed rest, light walking only]

**Dietary Requirements:** [e.g., Low sodium, liquid diet, no restrictions]

## **4. Wound Care / Medical Device Management**

[Insert instructions for dressing changes, incision care, or use of medical equipment if applicable.]

## **5. Warning Signs (Seek Immediate Medical Attention If:)**

- Fever over [Insert Temperature]
- Increased pain not relieved by medication
- Shortness of breath or chest pain
- [Insert specific symptom related to condition]

## **6. Contact Information**

If you have questions regarding this plan, please contact our office at [Insert Phone Number] during business hours.

Sincerely,

[Provider Signature]

[Provider Name and Title]

[Facility Name]