INSTRUCTIONS FOR EMERGENCY DEPARTMENT PATIENTS

1. It is IMPORTANT to see your DOCTOR OR PRIMARY CARE PROVIDER. Emergency Care may be incomplete without proper follow-up. Symptoms sometimes change or new symptoms might arise after you leave the Emergency Department. It is important that you call your doctor if you become worse in any way, or return to the Emergency Department. You are strongly urged to follow-up with your physician to assure complete and thorough care.
   Please schedule a follow-up appointment with: ______________________________ within ______ day(s)
   Phone: __________________
   □ As needed
   Please take your discharge instructions and the medication reconciliation form to your next doctor’s appointment.

2. Your preliminary diagnosis is: ____________________________________________

3. □ Your x-rays have been read by the Emergency Department Doctor. They will be reviewed by a Radiologist (x-ray specialist). You and/or your doctor will be notified if necessary.

4. Instructions for your continuing care: ____________________________________

5. Please read the accompanying instruction sheet on: _________________________

6. Medications prescribed:
   □ The medications you were taking prior to your Emergency Department visit, to the best of our knowledge, are listed on the Medication Reconciliation Form. New medications prescribed during your Emergency Department visit are listed on the Medication Reconciliation form. You are being provided a copy of this form to keep with you as a medication list and to review with your Primary Care Physician as soon as possible.

7. Return to the Emergency Department or call your doctor immediately if: __________________________
   __________________________________________

Special Instructions:

________________________________________

________________________________________

________________________________________

Date: __________ Time: __________ Physician/Mid-level Signature: __________

I have read and understood the instructions above.

Date: __________ Time: __________ Patient/Guardian Signature: __________

   Relationship: ____________________________

Date: __________ Time: __________ Witness Signature: __________________

SIGNED ORIGINAL - CHART

COPY GIVEN TO PATIENT