MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
DIRECTORATE OF MEDICAL SERVICES PATIENT FORMS	NAVHOSPPNCLAINST 5213.6B	01 Oct 2015

LOCAL FORM TITLE *(Optional)*
URGENT CARE CENTER DISCHARGE INSTRUCTIONS

Tricare Center: 1-(877)-TRICARE (874-2273)
Naval Hospital Central Appointments: (850)-505-7171 **Option 2 -** Appointments **Option 3 -** Referral
Suicide Hotline: 800-784-2433 800-273-8255 850-438-1617
Nurse Advice Line: 1-800-TRICARE (1-800-874-2273), **Option 1**

You were seen by: _____ **Diagnosis:** _____

Special Instructions: _____

_____

Instruction Sheets Given:

☐ Asthma ☐ Back/Neck Injury ☐ Urinary Tract Infection ☐ Upper Respiratory Infection ☐ Otitis Media ☐ Eye Injury
☐ Fever ☐ Abdominal Pain ☐ Vomiting/Diarrhea ☐ Threatened Miscarriage ☐ Wound Care ☐ Crutches
☐ PID ☐ Sprain/Fracture ☐ Mosby Other: _____

Medications:

☐ You have been prescribed _____ . Please take as directed.

☐ You have been given medication that may make you sleepy, affect your judgment, or affect your ability to drive or operate heavy machinery.

Radiology:

☐ A final reading for your x-ray will be done by a radiologist within 48 hours.

☐ You have been scheduled for a CT US on _____ at _____

Follow-up:

☐ Follow up with your PCM as needed or in _____ days for: ☐ Suture/Staple removal ☐ Wound Care Other: _____

☐ Return to Urgent Care Center in _____ days for: _____

☐ A consult has been placed for _____. Call the Central Appointments after 2 working days for Consult information.

I understand that the treatment I received was rendered on an emergency basis only and is NOT meant to take the place of complete care from the appropriate clinic. Furthermore, I may have been released before all of my medical problems were apparent, diagnosed and/or treated. If my condition worsens, I have been instructed to return to the Urgent Care Center or to the appropriate clinic for further care. I have read and understand the above, received a copy of this form and applicable instruction sheets, and will arrange for follow-up care.

*****TRICARE STATEMENT*****

You are not obligated to use any consulting provider suggested to you by the Urgent Care Center Staff. You may choose your own health care provider.

Signature: _____ Phone Number + Area Code: _____

☐ Patient ☐ Relative ☐ Friend

Instructed by: _____ Date: _____

School / Work Statement:

☐ May return to school / work without restrictions

☐ No physical activity until _____

☐ Will require _____ days off from school / work

☐ Must be re-evaluated by _____ physician before returning to work / school

☐ _____ was here with relative / child

☐ Sick in Quarters _____ days

☐ Light Duty _____ days

*** Give Original to Patient*** *** Place Copy in Chart***

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	