URGENT CARE

Acute illness visit

Blank documentation outlines. Adapt to the encounter and your practice requirements; complete only findings and care actually documented.

ENCOUNTER

Patient name:

Date of birth:

Date and time of encounter:

Clinician:

HISTORY

Chief concern, onset and symptom course

Associated symptoms and pertinent negatives actually elicited

Exposures and treatment already tried

Relevant history, medications and allergies

EVALUATION

Vitals measured, with units and time

Focused examination findings

Testing obtained, results and pending tests

ASSESSMENT AND MANAGEMENT

Working diagnosis and differential

Reasoning for testing and treatment decisions

Treatment provided and response

Disposition and rationale

Pending-result follow-up owner and communication plan

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding