URGENT CARE

Injury assessment

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:

INJURY HISTORY

Date, time and mechanism

Site and laterality

Symptoms, function and relevant prior injury

Relevant medical history, medications and allergies

EVALUATION

Vitals measured, with units

Examination findings including relevant functional and neurovascular assessment

Imaging or other tests and interpretation

ASSESSMENT AND MANAGEMENT

Working diagnosis and differential

Treatment, immobilization or other intervention actually provided

Reassessment and response

Activity guidance discussed

Referral or transfer decision and rationale

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding