URGENT CARE

Laceration repair note

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:

WOUND EVALUATION

Time and mechanism of injury

Site, laterality, length and depth

Contamination, foreign body and associated injury assessment

Functional and neurovascular findings

Tetanus history assessed and action taken

Relevant history, medications and allergies

CONSENT AND PROCEDURE

Options, risks and alternatives discussed; consent obtained or declined

Site verification

Anesthetic agent, concentration, amount and route if used

Cleansing, irrigation and exploration performed

Closure method, material and number of sutures or staples if used

Dressing, complications and patient response

DISPOSITION

Post-procedure reassessment

Wound care and return precautions discussed

Follow-up and removal plan if applicable