## Urgent Care or Emergency Department Discharge Continuity and Coordination of Care Report

**Today's date:** _____

**Patient name:** _____ **Date of birth:** _____

**Date of visit:** _____ **Primary diagnosis:** _____

**To:** _____
Health Care Provider

**Address:** _____ **Phone:** _____

_____ **Fax:** _____

Your patient was discharged on the above date with the above diagnosis. This information is being sent to you for your review and inclusion in the patient's medical record.

The treatment plan and discharge instructions are attached.

**Comments:** _____

_____

Upon discharge, your patient was advised to follow up with their health care provider within _____ days for further management of their condition.

Respectfully submitted,

_____
(Health Care Provider signature)

**Printed name:** _____ **Phone:** _____

**Address:** _____

_____

_____

**cc:** _____