Date Patient No.

Docter's Note

Diagnosis	Patient Details	
	Patient Name	
List all medical restrictions (if any)	Arrival Date Time	Discharged Date Time
	PATIENT IS TO RETURN TO ☐ Work ☐ School ☐ Inpatient Treatment ☐ Alternative Medical Center ☐ Other:_____ WITHIN _____ DAYS OF ABOVE DATE	
x _____ Medical Professional _____ Date		_____ Dr. Signature