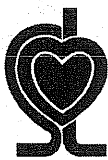

ST. LUKE COMMUNITY HOSPITAL
EMERGENCY ROOM
PATIENT DISCHARGE AND FOLLOW-UP INSTRUCTIONS

St. Luke Community Healthcare Network
107 6th Ave. S.W., Ronan, MT 59864
406-676-4441 - FAX 406-528-5378

Name: Date:

MEDICATIONS PRESCRIBED: Use only as directed.

Medication name and strength	Amount dispensed	Schedule/Duration
1.		
2.		
3.		

☐ Dispense as written ☐ May substitute

____
Provider signature

INSTRUCTIONS:

INSTRUCTION SHEET(S) PROVIDED:

TRAUMA
- ☐ Burn care
- ☐ Eye injury care
- ☐ Fracture/splint/cast
- ☐ Head injury care
- ☐ Soft tissue injury
- ☐ Wound care

NON-TRAUMA
- ☐ Chest pain
- ☐ Clear liquid diet
- ☐ Croup
- ☐ Fever control
- ☐ Gastroenteritis
- ☐ Hypertension
- ☐ Nosebleed
- ☐ Insect bites/stings
- ☐ Otitis media
- ☐ Upper respiratory infection
- ☐ Urinary tract infection
- ☐ Abdominal pain
- ☐ Respiratory home therapy instruction

REFERRAL(S)

Please follow up with:
- ☐ Your usual physician
- ☐ ______________________
- ☐ in ______ days
- ☐ for suture removal
- ☐ on (date) at (time)
- ☐ for test results
- ☐ for further testing and/or follow-up

Activity: ☐ No restriction ☐ Other: ______________________

Diet: ☐ Usual diet ☐ Other: ______________________

I understand that the treatment I received in the emergency room was rendered on an emergency basis only and is not meant to replace the care of a personal physician. I further understand that my release does not imply that all my medical problems were apparent, diagnosed, or treated during this visit. I have received specific instructions regarding follow-up care, and am instructed to contact my personal physician or return to St. Luke Community Hospital, or another emergency facility, should my condition worsen. I understand the above, and have received a copy of this form and the indicated instruction sheets. I will arrange follow-up care.

Instructed by:	*Time*

X ______________________

☐ Patient ☐ Relative:__________ ☐ Other:__________

WORK/SCHOOL STATEMENT

The above person was seen as a patient today. He/she may return to work/school: ☐ immediately ☐ in ______ days

Restrictions *after* return to work/school: ☐ none ☐ No athletics/phys. ed. ☐ other:______________________

____

Restrictions apply for: ☐ __________days ☐ Until recheck __________

☐ He/she must be reevaluated in ______days, *before* returning to work/school.

☐ ______________________

____

Dates and restrictions may require modification by a physician as treatment progresses.

Signature: ______________________