Doctors Work Note Template

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| **Doctors Details:** |
| Full Name: | [First Name] [Last Name] |
| Qualification: | [Medical Qualification(s)] |
| Medical License Number: | [License Number] |
| Phone Number: | [0000-000-000] |
| Email Address: | [email@highfile.com] |
| Practice/Hospital Name: | [Name of the Medical Practice/Hospital] |
| Practice/Hospital Address: | [Address of the Medical Practice/Hospital] |
| **Patient Details:** |
| Patient Name: | [First Name] [Last Name] |
| Date of Birth: | [MM/DD/YYYY] |
| Gender: | [Male/Female/Other] |
| Phone Number: | [0000-000-000] |
| Email Address: | [email@highfile.com] |
| Address: | [Complete Address] |
| **Medical Consultation Details:** |
| Date of Consultation/ Examination: | [MM/DD/YYYY] |
| Time of Consultation/ Examination: | [Time] |
| **Illness/Condition** | **ICD-10 Code** | **Date Diagnosed** |
| [Name of Illness/ Condition] | [ICD-10 Code for the Illness/ Condition] | [MM/DD/YYYY] |
| Add as needed |
| **Medical Recommendation/Prescription:** |
| Treatment Plan: | [Detailed treatment plan] |
| Prescribed Medication: | [Name, dosage, frequency, and duration of the prescribed medicine] |
| Special Precautions/Notes: | [Any special instructions for the patient] |
| **Work Restriction Details:** |
| Expected Duration of Absence from Work: | [Start Date] - [End Date] |
| Work Restrictions (If any): | [Detailed restrictions if any, for example, no heavy lifting, frequent breaks, etc.] |
| Fitness for Duty (check one): |
|[ ]  **Full Duty:** The patient is fit to return to full normal duty without restrictions. |
|[ ]  **Light Duty:** The patient may return to work with the following restrictions: [Specify restrictions] |
|[ ]  **Not Fit for Duty:** The patient is not fit to return to work. |
| **Follow-up Appointment Details:** |
| Follow-up Appointment Date: | [MM/DD/YYYY] |
| Follow-up Appointment Time: | [Time] |
| Notes for the Follow-up Appointment: | [Any specific tests/observations to be made during the follow-up] |
| This document certifies that the above-named patient under my care has been evaluated and treated for the above-mentioned medical condition(s). The information provided herein is accurate to the best of my knowledge and based on the current health status of the patient. |
| **Signature:** | [Signature] |
| **Date:** | [MM/DD/YYYY] |