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] | |