

**MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA**  
 For use of this form, see AR 40-66; the proponent agency is the office of the Surgeon General

REPORT TITLE <b>EMERGENCY DEPARTMENT DISCHARGE INSTRUCTIONS - PEDIATRIC</b>	OTSG APPROVED <i>(Date)</i> (YYYYMMDD)
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The examination and treatment you received has been rendered on an emergency basis and is not intended to substitute or provide complete medical care. Often additional care is needed and this will be provided by the general or specialty clinic to which you have been referred. All tests will be reviewed by doctors who specialize in their interpretation at a later date and you will be contacted if there are findings different from the emergency department.

**Diagnosis:** \_\_\_\_\_

**Discharge instructions provided (check/circle one)**

- |  |  |
|--|--|
| <input type="checkbox"/> Abdominal pain - child    | <input type="checkbox"/> Fever > 3 months                  |
| <input type="checkbox"/> Acute bronchitis - child  | <input type="checkbox"/> Head injury                       |
| <input type="checkbox"/> Allergic reaction         | <input type="checkbox"/> Influenza - child                 |
| <input type="checkbox"/> Asthma - child            | <input type="checkbox"/> Otitis media                      |
| <input type="checkbox"/> Bronchiolitis             | <input type="checkbox"/> Pharyngitis/tonsillitis - child   |
| <input type="checkbox"/> Child safety              | <input type="checkbox"/> Seizure - child                   |
| <input type="checkbox"/> Conjunctivitis            | <input type="checkbox"/> Sprains/strains/bruises/fractures |
| <input type="checkbox"/> Vomiting/diarrhea - child | <input type="checkbox"/> Urinary tract infection           |
| <input type="checkbox"/> Dehydration - child       | <input type="checkbox"/> Viral upper respiratory infection |
| <input type="checkbox"/> Fever infant              | <input type="checkbox"/> Other (specify): _____            |

Wound care/burn care: Keep the wound clean. Apply the ointment and change the dressing \_\_\_\_ times per day. If you note swelling, pus, foul odor, fever, redness, increased pain, or have any concerns return to PCM or ED.

Stitches/staples removed in \_\_\_\_ days by PCM/ED.

Wound checked in \_\_\_\_ days by PCM/ED

**\* PCM is primary care managers clinic.**  
**\*\*ED is emergency department**

**Additional Instructions:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medications:**  Medication reconciliation completed by ED provider and list given to patient/parent.  
 Medication reconciliation NOT indicated.

Please make the following changes to your child's home medications: \_\_\_\_\_

Your provider has prescribed the following medications: \_\_\_\_\_

All medications have potential side effects and medications can interact with each other. After you review your medications, notify an ED staff member or the pharmacy if you have questions.

You child has been prescribed medications which decrease alertness.

**Follow-up:**

- Make an appointment in \_\_\_\_ days at your primary care managers clinic, or sooner if your child becomes worse.
- A physician was consulted to continue your child's care in the \_\_\_\_\_ clinic. Please call for an appointment.
- TRICARE appointment number 1-866-299-4234 or 573-596-1490     Front Desk 596-0035     Family Practice 596-1765     Pediatrics 596-1766
- Ozark St Robert 596-0064     Podiatry 596-1767     EENT 596-0048     Gen Surg 596-1769     Ortho 596-1764

The patient and/or the representative verbalizes/demonstrates understanding of medications, treatment plans, pain management and follow-up care. I understand and have received a copy of my instructions regarding my medical care and follow-up care as noted above. I understand that if there is a serious change in my condition I should contact my regular clinic or return to the ED.

Patient/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACCIDENTAL INGESTION? Call 911 or Poison Control 1-800-222-1222**

**SUICIDE ON YOUR MIND? Help is available. Notify ED staff member, Military Police, or Military One Source 1-800-342-9647**

**YOUR FEEDBACK IS IMPORTANT TO US! Please complete and return the survey you receive in the mail regarding your ED visit.**

PREPARED BY (Signature & Date)	DEPARTMENT/SERVICE/CLINIC <b>GLWACH ER</b>	Date (YYYYMMDD)								
Patients Identification <i>(For typed or written entries give: Name- Last, First, Middle; grade; date; hospital or medical facility)</i>	<table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> HISTORY/PHYSICAL</td> <td><input type="checkbox"/> FLOW CHART</td> </tr> <tr> <td><input type="checkbox"/> OTHER EXAMINATION OR EVALUATION</td> <td><input type="checkbox"/> OTHER PIXIS <i>(Specify)</i></td> </tr> <tr> <td><input type="checkbox"/> DIAGNOSTIC STUDIES</td> <td></td> </tr> <tr> <td><input type="checkbox"/> TREATMENT</td> <td></td> </tr> </table>		<input type="checkbox"/> HISTORY/PHYSICAL	<input type="checkbox"/> FLOW CHART	<input type="checkbox"/> OTHER EXAMINATION OR EVALUATION	<input type="checkbox"/> OTHER PIXIS <i>(Specify)</i>	<input type="checkbox"/> DIAGNOSTIC STUDIES		<input type="checkbox"/> TREATMENT	
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