**OB/GYN DOCTOR’S NOTE**

****  
**[Ob/Gyn Clinic Name]**

**[123 Health St.,]**

**[Wellness City, NY 12345]**

|  |  |  |
| --- | --- | --- |
| Phone: (123) 456-7890 | Fax: (123) 456-7891 | www.urgentcareclinic.com |

**Patient Information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  |  | Date of Birth: | \_\_/\_\_/\_\_\_\_ |
|  | |  |  | |
| Patient ID: |  |  | Date of Visit: | \_\_/\_\_/\_\_\_\_ |

**Diagnosis/Assessment:**

|  |
| --- |
| **[Briefly describe the patient's medical condition, including the patient's symptoms, vital signs (e.g., blood** |
| **pressure, temperature), and any physical examination findings.]** |

**Treatment Plan:**

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment Provided: |  | | |
| Recommended Rest Period (if any): | | |  |
| Medications Prescribed (if any): | |  | |

**[Patient’s Name]** is advised to take leave from work/school:

|  |  |
| --- | --- |
| Yes | No |

Expected Date of Return (if applicable): **[MM/DD/YYYY]**

**Doctor Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Dr. | Specialty: |  |
| Signature: |  | Date: |  |
| License no: |  |  | |