Medical Statement for Surgery Recovery

Date: _____

Patient Name: _____

Date of Birth: _____

Surgery Performed: _____
Date of Surgery: _____

Post-Operative Condition:

Care Instructions:

- Medications prescribed: _____
- Wound care: _____
- Physical activity limitations: _____
- Special dietary restrictions: _____
- Other instructions: _____

Follow-Up Appointments:

- Date & Time: _____
- Provider: _____

Healthcare Provider Name: _____

Provider Signature: _____