

**McLaren Print System Order**

**Order No: 48209 Reprint Previous Order No: 6599**  
**Order Date: 2019-08-29**  
**User: Shannon Pierce**  
**Phone: 810-667-7040**

**Ship Location: LapeerOccupational and Convenient Care**  
**1254 N Main St**  
**Lapeer, MI 48446**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 65100**  
**Dept Name: Lapeer Occupational and Convenient Care**  
**Company Number: 810**

**Order Total Price: 94.75**

**Item Number: MM-34488-D**  
**Item Description: McLaren Occupational Health/Convenient Care Center Patient Discharge Instructions**  
**Revision Date: 8/2019**  
**Print: 1 sided black and white**  
**Paper: 3 Part (White, Yellow, Pink)**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: None**  
**Misc Info:**

MCLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER  
INPATIENT DISCHARGE INSTRUCTIONS

PRINT ORDER

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TIME IN \_\_\_\_\_ TIME OUT \_\_\_\_\_

<p><b>WOUNDS</b></p> <ul style="list-style-type: none"> <li>..... See your doctor/clinic or go to the Emergency Department for any of the following:             <ul style="list-style-type: none"> <li>- Signs of infection (redness, swelling, pain, pain, fever and/or chills)</li> <li>- Bleeding</li> <li>- Numbness, tingling, or weakness of the hand/foot</li> </ul> </li> <li>..... Report for observation per discharge instructions</li> <li>..... Take medications as directed</li> <li>..... Keep the wound clean and dry</li> <li>..... Clean the wound twice daily (AM &amp; PM) with a mixture of half warm water and half hydrogen peroxide</li> <li>..... Apply antibiotic ointment/discharge as instructed</li> <li>..... Protect wound with a sterile dressing or band if not as needed</li> <li>..... Your laboratory information will be mailed to you</li> <li>..... Have someone accompany you _____ days</li> <li>..... Tell your doctor/clinic or return here for a wound check if _____</li> </ul> <p><b>SPRAINS, STRAINS, BRUISES and FRACTURES</b></p> <ul style="list-style-type: none"> <li>..... Elevate the injured part for 2-3 days</li> <li>..... Ice apply to the injured area for the first 12 hours and then as needed to reduce swelling</li> <li>..... Report for observation per discharge instructions</li> <li>..... Squander for observation per discharge instructions</li> <li>..... Do not remove cast/wrap</li> <li>..... Do not get your cast/wrap wet</li> <li>..... Do not wear shoes/cast</li> <li>..... See your doctor/clinic, emergency or go to the Emergency Department if:             <ul style="list-style-type: none"> <li>- Begins or feels better your hours beyond that, cast, cast or band</li> <li>- Cast/castband _____</li> <li>- Pain/weight bearing and you are seen for swelling or _____</li> <li>- You or your doctor suspect damage and/or wrap does not _____</li> </ul> </li> </ul> <p><b>DRUG RESISTANCE AND RESISTANCE</b></p> <ul style="list-style-type: none"> <li>..... Do not take any of the pills to reduce swelling</li> <li>..... For infections and pain medications for 2-3 times a day</li> <li>..... Do not take other medicine affecting the affected area</li> <li>..... Take medications as prescribed</li> <li>..... Contact your doctor/clinic or go to the Emergency Department if any of the following:             <ul style="list-style-type: none"> <li>- Change in vision or loss of vision</li> <li>- Increasing pain, redness, or swelling</li> <li>- Fever</li> </ul> </li> <li>..... Do not eat, drink or take any other medicine while on these medications</li> <li>..... Do not take any other medicine while wearing an eye patch</li> <li>..... See your doctor/clinic for follow-up _____ days</li> <li>..... Return here for recheck in 3-5 days</li> </ul>	<p><b>OCCUPATIONAL MEDICINE</b></p> <p><b>PROVIDER SIGNATURE</b> _____</p> <p><b>DATE/TIME</b> _____</p> <p><b>PHYSICIAN'S NAME</b> _____</p> <p><b>PRINT</b></p>
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**IMPORTANT NOTE:**  
With the exception of Occupational Care visits, this center is intended to provide expedient care for your convenience. The observation and treatment that you have received has been on an immediate care basis only. It was not intended to be a substitute or replacement for complete medical care. We encourage you to report this information to your doctor/clinic and follow up with your doctor/clinic as directed.

I have given the opportunity to ask questions and understand the instructions given to me. I hereby acknowledge receipt of the instructions above and realize that I may be released before all of my medical problems are known or treated. I will arrange for follow-up care and provide the instruction sheet to that provider, as instructed.

**PATIENT'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**WENTZ** Employee (mark related visit only)  
1000 Oak Medical Records  
Pleasant, Michigan  
48166-1000  
INPATIENT DISCHARGE INSTRUCTIONS