

## McLaren Print System Order

Order No: 54870 Reprint Previous Order No: 6599  
 Order Date: 2020-06-19  
 User: Cindy Powers  
 Phone: 989-773-1166

Ship Location: MCLAREN CENTRAL READYCARE  
 1523 S MISSION ST  
 MT PLEASANT, MI 48858

### Forms

Quantity: 100  
 Paragon Dept No: 53037  
 Dept Name: MCLAREN CENTRAL READYCARE  
 Company Number: 810

Order Total Price: 19.20

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: 2 Hole Top  
 Misc Info:

MCLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER  
 INPATIENT DISCHARGE INSTRUCTIONS

OTHER ORDER

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

<p><b>WOUNDS</b></p> <p>See your doctor/clinic or go to the Emergency Department for any of the following:</p> <ul style="list-style-type: none"> <li>- Signs of infection (redness, swelling, pain, pus, fever and/or chills)</li> <li>- Bleeding</li> <li>- Numbness, tingling, or weakness of the hand/wrist</li> </ul> <p>Request for occupational care discharge instructions</p> <p>See medications as directed</p> <p>Apply the correct bandage(s)</p> <p>Clean the wound twice daily (AM &amp; PM) with a mixture of half warm water and half hydrogen peroxide</p> <p>Apply antibiotic ointment/discharge as indicated</p> <p>Protect wound with a cover/dressing or band-aid as needed</p> <p>Your discharge instructions take priority over any other instructions on hand</p> <p>See your doctor/clinic or return here for a wound check if:</p> <ul style="list-style-type: none"> <li>- Pain</li> <li>- Swelling</li> <li>- Bruises, BRUISES and FRACTURES</li> <li>- Bleeds the wound part for 1-2 days</li> <li>- Swells up for the wound area for the first 12 hours and then up</li> <li>- Swells to reduce swelling</li> </ul> <p>Request for occupational care discharge instructions</p> <p>See medications as directed</p> <p>Do not remove your splint</p> <p>Do not get your splint wet</p> <p>See your doctor/clinic, immediately or go to the Emergency Department if:</p> <ul style="list-style-type: none"> <li>- Begins or feels better your hand/before that, cold, numb or tingly</li> <li>- Tingling/numbness</li> <li>- Painful weight bearing and you are unable to tolerate it</li> <li>- You are not getting support/bandage and/or wrap tight right</li> <li>- Swelling</li> </ul> <p><b>DRUGS AND PRESCRIPTIONS</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 14 days, four times a day. Start taking after reaching the affected area</li> <li>- See 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>- Nausea/vomiting or 10 hours and longer using your discharge medication</li> <li>- ALLERGY also on separate medication while wearing on your patch</li> <li>- See your doctor/clinic for ALLERGY if _____</li> <li>- Return here for re-check in 3-5 days</li> </ul>	<p><b>OCCUPATIONAL MEDICINE</b></p> <p>PROF. OCCUP. MEDICIN. requires to wear protective</p> <p>Company Name: _____</p> <p>Treatment: _____</p> <p>Condition is: <input type="checkbox"/> Work related <input type="checkbox"/> Not work related</p> <p>Refer to Physician/Doc: _____</p> <p><input type="checkbox"/> Make appointment to be seen in _____ Day</p> <p><input type="checkbox"/> Return here for follow-up Day _____ Time _____</p> <p>Refer to Physician/Doc: _____</p> <p><input type="checkbox"/> Today _____ Date _____</p> <p><input type="checkbox"/> Pending further evaluation and treatment as scheduled above</p> <p>Patient may return to restricted work on _____</p> <p>Work restrictions include (check):</p> <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Bending</td> <td><input type="checkbox"/> Prolonged sitting</td> </tr> <tr> <td><input type="checkbox"/> Reaching</td> <td><input type="checkbox"/> Prolonged standing</td> </tr> <tr> <td><input type="checkbox"/> Climbing</td> <td><input type="checkbox"/> Pushing and pulling</td> </tr> <tr> <td><input type="checkbox"/> Carrying</td> <td><input type="checkbox"/> Right-handed work</td> </tr> <tr> <td><input type="checkbox"/> Lifting</td> <td><input type="checkbox"/> Left-handed work</td> </tr> <tr> <td><input type="checkbox"/> Lifting</td> <td><input type="checkbox"/> Patient or customer</td> </tr> <tr> <td><input type="checkbox"/> Lifting/restriction of _____ pounds</td> <td><input type="checkbox"/> Drive/operate equipment</td> </tr> </table> <p><input type="checkbox"/> Patient is on total disability</p> <p>Employer should give this information to their supervisor or soon as possible</p> <p>DR employees should report to their DR Medical Department with the information when in 3-5 days</p> <p><b>DATE/TIME</b></p> <p>_____          _____</p> <p><b>PRESCRIPTIONS AND OTHER INSTRUCTIONS</b></p> <p>_____          _____</p>	<input type="checkbox"/> Bending	<input type="checkbox"/> Prolonged sitting	<input type="checkbox"/> Reaching	<input type="checkbox"/> Prolonged standing	<input type="checkbox"/> Climbing	<input type="checkbox"/> Pushing and pulling	<input type="checkbox"/> Carrying	<input type="checkbox"/> Right-handed work	<input type="checkbox"/> Lifting	<input type="checkbox"/> Left-handed work	<input type="checkbox"/> Lifting	<input type="checkbox"/> Patient or customer	<input type="checkbox"/> Lifting/restriction of _____ pounds	<input type="checkbox"/> Drive/operate equipment
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PATIENT'S SIGNATURE \_\_\_\_\_ DATE/TIME \_\_\_\_\_

DR PHYSICIAN'S NAME \_\_\_\_\_

**IMPORTANT NOTE:**

With the exception of Occupational Care visits, this center is intended to provide specific care for your convenience. The examination 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. DR encourage you to report this information to your doctor/clinic and follow up with your doctor/clinic as directed.

I was 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 instructions when so provided as instructed.

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

WENT'S Employee (mark related visits only)  
 1000 CMC Medical Records  
 Print: Patient

see order 6/16/19

INPATIENT DISCHARGE INSTRUCTIONS