

**McLaren Print System Order**

**Order No: 56019 Reprint Previous Order No: 6599**  
**Order Date: 2020-08-11**  
**User: Cindy Powers**  
**Phone: 989-773-1166**

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

**Forms**

**Quantity: 500**  
**Paragon Dept No: 53037**  
**Dept Name: MCLAREN CENTRAL READYCARE**  
**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 \_\_\_\_\_

**WOUND CARE**

- \_\_\_\_\_ See your doctor/clinic or go to the Emergency Department for any of the following:
  - Signs of infection (redness, swelling, pain, pus, fever and/or chills)
  - Bleeding
  - Numbness, tingling, or weakness of the extremity
- \_\_\_\_\_ Report for observation per discharge instructions
- \_\_\_\_\_ Take medications as directed
- \_\_\_\_\_ Keep the wound clean and dry
- \_\_\_\_\_ Clean the wound twice daily (AM & PM) with a mixture of half warm water and half hydrogen peroxide
- \_\_\_\_\_ Apply antibiotic ointment (directions on label)
- \_\_\_\_\_ Protect wound with a sterile dressing or band that is needed
- \_\_\_\_\_ Your physician/clinician will explain why
- \_\_\_\_\_ Have someone monitor you \_\_\_\_\_ days
- \_\_\_\_\_ Stop your activities or return here for a wound check if \_\_\_\_\_

**SPRAINS, STRAINS, BRUISES and FRACTURES**

- \_\_\_\_\_ Elevate the injured part for 2-3 days
- \_\_\_\_\_ Ice packs to the injured area for the first 12 hours and then as needed to reduce swelling
- \_\_\_\_\_ Report for observation per discharge instructions
- \_\_\_\_\_ Take medications as prescribed
- \_\_\_\_\_ Do not remove cast/wrap
- \_\_\_\_\_ Do not get your cast/wrap wet
- \_\_\_\_\_ Do not wear shoes/walkers
- \_\_\_\_\_ See your doctor/clinic, emergency or go to the Emergency Department if
  - Begins or feels better your hours beyond that, cast, casted or bandaged
  - Cast/castling \_\_\_\_\_
  - Pain/weight bearing and you are seen for swelling or \_\_\_\_\_
  - You or your doctor suspect damage and/or deep laceration \_\_\_\_\_

**DRUG RESISTANCE AND RESISTIONS**

- \_\_\_\_\_ Do not take any of the pills to reduce swelling
- \_\_\_\_\_ For infections and pain medications for 2 minutes four times a day. Read labels after receiving the affected area
- \_\_\_\_\_ Take medications as prescribed
- \_\_\_\_\_ Contact your doctor/clinic or go to the Emergency Department if any of the following:
  - Change in vision or loss of vision
  - Increasing pain, redness, or swelling
  - Fever
- \_\_\_\_\_ Never use alcohol or OTCs and never using any alcohol products
- \_\_\_\_\_ DO NOT drive or operate machinery while wearing an eye patch
- \_\_\_\_\_ See your doctor/clinic for follow up \_\_\_\_\_ days
- \_\_\_\_\_ Return here for recheck in 3-5 days

**OCCUPATIONAL MEDICINE**

**PROVIDER SIGNATURE** \_\_\_\_\_ **DATE/TIME** \_\_\_\_\_

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

**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. 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** Emphasize (mark, embossed, white, only)  
100% OTC Medical Records  
Print, Patient

see order 6/26/19

**PATIENT DISCHARGE INSTRUCTIONS**