McLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER
PATIENT DISCHARGE INSTRUCTIONS

Please Check Location:
- ❑ 1254 N, Main St., Lapeer, MI 48446 (810) 667-7040
- ❑ 1523 S. Mission St., Mt. Pleasant, MI 48858 (989) 779-5600
- ❑ 1523 S. Mission St., Suite 2, Mt. Pleasant, MI 48858 (989) 773-1166
- ❑ 2313 E. Hill Rd., Grand Blanc, MI 48439 (810) 496-0900
- ❑ 6910 S. Cedar St., Lansing, MI 48911 (517) 975-3110

OFFICE STAMP

McLaren Redi Care South - Lansing
6910 South Cedar Street
Lansing, MI 48911
(517) 975-3110

NECK and BACK PAIN
_____ Go to the Emergency Department immediately for any of the following:
- Loss of bladder or bowel control
- Numbness in arms, legs, hands or feet
- Weakness in arms, legs, hands or feet
- Fever or headache
- Abdominal pain
- Sudden, severe increase in pain

_____ Rest in comfortable position for two days
_____ Low local heat and warm tub soaks for comfort
_____ Back exercises as prescribed when acute pain is resolved
_____ Soft cervical collar for comfort
_____ Take medications as directed
_____ See your doctor or clinic within 3 days for follow-up

HEAD INJURIES and HEADACHES
_____ Go to the Emergency Department immediately for any of the following
- Sudden change in behavior/vision
- Sudden development or worsening of headache
- Vomiting
- Confusion and/or disorientation
- Trouble walking

**Awaken sleeping patients every 2-3 hours to check for the above changes.
_____ No alcohol
_____ Take medications as ordered
_____ No driving, or dangerous activity until approved by your doctor/clinic
_____ See your doctor/clinic within 2 days for follow-up
_____ Tylenol for discomfort per package instructions
_____ Ibuprofen for discomfort per package instructions

CHEST PAIN
_____ Go to nearest Emergency Department for any of the following:
- Worsening pain
- Radiation of pain into neck, jaw or arms
- Nausea and/or vomiting
- Shortness of breath
- Sweats

_____ See your doctor within 3 days for follow-up
_____ Do not smoke
_____ Take medications as directed

ABDOMINAL PAIN
_____ Contact your doctor or go to the Emergency Department for any of the following:
- Pain worsens or changes location
- Vomiting develops
- Fever develops
- Abdomen swells
- Blood in vomit, urine, or stool
- You stop passing gas or stool
- You become faint or weak

_____ Any new and/or severe abdominal pain that does not improve or resolve within 8 hours should be re-evaluated by your doctor or Emergency Department
_____ Clear liquid diet until pain resolves
_____ Take medications as ordered
_____ See your doctor/clinic within 3 days for follow-up

TIME IN: _____ TIME OUT: _____

OCCUPATIONAL MEDICINE
FIRST INJURY REPORT - RETURN TO WORK STATEMENT

Company Name_____

Treatment _____

Condition is _____Work-related _____Not work-related
_____Undetermined

Referral Physician/Clinic _____

_____ Make appointment to be seen in _____ days
_____ Return here for follow up: Date _____
Time _____

Patient may return to regular work/school/sports

_____ Today _____ Date
_____ Pending further evaluation and treatment as scheduled above

Patient may return to restricted work on _____

Work restrictions include (hrs/day):

_____ Bending	_____ Prolonged sitting
_____ Squatting	_____ Prolonged standing
_____ Reaching	_____ Pushing and pulling
_____ Driving	_____ Right handed work
_____ Climbing	_____ Left handed work
_____ Walking	_____ Patient on crutches
_____ Lifting	_____ Dust/fume exposure
_____ Other	

_____ Lifting restriction of _____ pounds

_____ Patient is on total disability

Employee should give this information to his/her supervisor as soon as possible.

GM employees should report to their GM Medical Department with this information within 24 hours.

DIAGNOSIS _____

PRESCRIPTIONS and OTHER INSTRUCTIONS

_____

_____

_____

_____
PHYSICIAN'S SIGNATURE **DATE/TIME**

_____
PRINTED PHYSICIAN'S NAME

IMPORTANT NOTE
With the exception of Occupational Care visits, this center is intended to provide episodic 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 intervention to your doctor/clinic and follow up with your doctor/clinic as directed.

I was given the opportunity to ask questions and I 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 this instruction sheet to that provider as instructed.

_____
PATIENT'S SIGNATURE **DATE**

WHITE: Patient
YELLOW: Employer (work-related visits only)
PINK: Medical Record

Patient Name:

Date of Birth:

PATIENT DISCHARGE INSTRUCTIONS