McLaren Business Products

McLaren Print System Order

Order No: 50749 Reprint Previous Order No: 6599
Order Date: 2019-12-03
User: Jessica Smith
Phone: 989-773-1166

Ship Location: McLaren Central ReadyCare/ attn: Jessica
1523 S. Mission St.
Mt. Pleasant , Mi 48858
Forms
Quantity: 500
Paragon Dept No: 75400
Dept Name: 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
PATIENT DISCHARGE INSTRUCTIONS

TIME IN _____ TIME OUT _____

WOUND CARE

SPRAINS, STRAINS, BRUISES and FRACTURES

EYE INJURIES and INFECTIONS

OCCUPATIONAL MEDICINE
FIRST AID/OPI 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 (he/she):

_____ Bending
_____ Squatting
_____ Reaching
_____ Driving
_____ Climbing
_____ Walking
_____ Lifting
_____ Urinal
_____ Lifting restriction of _____ pounds

_____ Prolonged sitting
_____ Prolonged standing
_____ Pushing and pulling
_____ Right handed work
_____ Left handed work
_____ Patient on crutches
_____ Dust/fume exposure

_____ Patient is on total disability

Employee should give this information to he/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

ID PHYSICIAN'S NAME

PRINT

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 information 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: Employee (work related visits only)
YELLOW: Medical Records
PINK: Patient

PATIENT DISCHARGE INSTRUCTIONS

Patient Name

Date of Birth