

**McLaren Print System Order**

**Order No: 56636 Reprint Previous Order No: 6593**  
**Order Date: 2020-09-04**  
**User: Theda Simmonds**  
**Phone: 989-393-2857**

**Ship Location: McLaren Occupational and Convenient Care - Bay City**  
**4 Columbus Ave Ste140**  
**Bay City, MI 48708,**

**Forms**

**Quantity: 2500**  
**Paragon Dept No: 69100**  
**Dept Name: Occupational Convenient Care**  
**Company Number: 810**

**Order Total Price: 453.00**

**Item Number: MM-34488-A**  
**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**

INSTRUCTIONS

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

Do not smoke or use tobacco products  
Do not drink alcohol while taking antibiotics

COMPANY NAME \_\_\_\_\_  
RETURN TO WORK ENVIRONMENT

Company Name \_\_\_\_\_  
Treatment \_\_\_\_\_  
Condition is \_\_\_\_\_ Not work-related \_\_\_\_\_

Return Physician/Date \_\_\_\_\_  
Make appointment to be seen in \_\_\_\_\_ days  
Return here for follow-up \_\_\_\_\_ Date \_\_\_\_\_  
Time \_\_\_\_\_

Patient may return to regular work/activities \_\_\_\_\_  
Today \_\_\_\_\_ Date \_\_\_\_\_  
Pending further evaluation and treatment as scheduled above

Patient may return to restricted work on \_\_\_\_\_  
Basic operations include (examples):  
\_\_\_\_\_ Pushing/pulling \_\_\_\_\_  
\_\_\_\_\_ Lifting \_\_\_\_\_  
\_\_\_\_\_ Carrying \_\_\_\_\_  
\_\_\_\_\_ Climbing \_\_\_\_\_  
\_\_\_\_\_ Digging \_\_\_\_\_  
\_\_\_\_\_ Drilling \_\_\_\_\_  
\_\_\_\_\_ Hoisting \_\_\_\_\_  
\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Patient is on total disability

Employee should give this information to their supervisor as soon as possible

OR employees should report to their OR Medical Department with the information within 24 hours

DISCUSS \_\_\_\_\_  
PRESCRIPTIONS AND OTHER INSTRUCTIONS \_\_\_\_\_  
\_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
PRINTED PATIENT'S NAME \_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
PRINTED PATIENT'S NAME \_\_\_\_\_

NOTE: Employees (and related individuals) who have received this form as an occupational case have only 1 year to request a compensation or reimbursement 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 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 \_\_\_\_\_  
NOTE: Employees (and related individuals) who have received this form as an occupational case have only 1 year to request a compensation or reimbursement for complete medical care. We encourage you to report this information to your doctor/clinic and follow up with your doctor/clinic as directed.

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Patient Discharge Instructions