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., Suite 2, Mt. Pleasant, MI 48858 (989) 773-1166
- ❑ 2313 E. Hill Rd., Grand Blanc, MI 48439 (810) 496-0900
- ❑ 4 Columbus Ave. Suite 140 Bay City, MI 48708 Phone: (989) 393-2850

OFFICE STAMP

1254 N. Main
Lapeer, MI 48446
(810) 667-7040

TIME IN: _____ TIME OUT: _____

VOMITING

_____ Contact your doctor or go to the Emergency Department for any of the following:
- Vomiting continues for more than 24 hours
- You become weak, dizzy, or faint
- Your emesis contains blood
- You develop abdominal pain
- You develop a fever greater than 101° F
- You feel that you are getting worse

_____ Take medications as prescribed
_____ No milk or dairy products while you are sick
_____ No food or drinks for 4 hours after vomiting then begin clear liquids in small frequent feedings
_____ Once you are better slowly advance your diet to normal as tolerated
_____ See your doctor/clinic within 3 days for follow up

DIARRHEA

_____ Contact your doctor or go to the Emergency Department for any of the following:
- Diarrhea continues for more than 24 hours
- You become weak, dizzy, or faint
- Your stool contains blood
- You develop abdominal pain and/or swelling
- You develop a fever greater than 101° F

_____ Take medications as prescribed
_____ Do not eat solid food, milk or dairy products while you are having diarrhea. Slowly reintroduce these foods back into your diet when you are better. Eat a BRAT diet – bananas, rice, applesauce, toast while you are having diarrhea.
_____ Clear liquids in frequent small feedings while you are having diarrhea

GYNECOLOGICAL PROBLEMS

_____ Your urine pregnancy test was POS / NEG
_____ If you are pregnant you should:
- Avoid alcohol and smoking
- Avoid medications unless approved by your doctor/clinic
- Begin prenatal care as soon as possible
- Go to the Emergency Department if you develop pain, bleeding, fever, weakness or dizziness

_____ Take medications as prescribed
_____ See your doctor/clinic for follow up within 3 days
_____ Avoid sexual intercourse until approved by your doctor/clinic

ELEVATED BLOOD PRESSURE

You had an elevated blood pressure reading today
If you are on medication(s) take them regularly as prescribed
See your doctor/clinic for a blood pressure check within 7 days

Your blood pressure reading today was _____

OTHER CONDITIONS

_____

_____

_____ Take medications as directed
_____ Follow up with your doctor/clinic in _____ days
_____ Contact your doctor/clinic or go to the Emergency Department if worsening or problems persists

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

Patient Name:

Date of Birth: