

**McLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER  
PATIENT DISCHARGE INSTRUCTIONS**

**Please**  1254 N. Main St., Lapeer, MI 48446 (810) 667-7040  
**Check**  1523 S. Mission St., Suite 2, Mt. Pleasant, MI 48858 (989) 773-1166  
**Location:**  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: \_\_\_\_\_

**WOUND CARE**

- \_\_\_\_\_ See your doctor/clinic or go to the Emergency Department for any of the following:
- Signs of infection (redness, swelling, pus, pain, fever and/or chills)
- Bleeding
- Numbness, tingling, or weakness of the injured part
- \_\_\_\_\_ Tylenol for discomfort per package instructions
- \_\_\_\_\_ Ibuprofen for discomfort per package 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 (bacitracin) as instructed
- \_\_\_\_\_ Protect wound with a loose bandage or Band-Aid as needed
- \_\_\_\_\_ Your tetanus immunization was updated today
- \_\_\_\_\_ Have sutures removed in \_\_\_\_\_ days
- \_\_\_\_\_ See your doctor/clinic or return here for a wound check in \_\_\_\_\_ days

**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
- \_\_\_\_\_ Tylenol for discomfort per package instructions
- \_\_\_\_\_ Ibuprofen for discomfort per package instructions
- \_\_\_\_\_ For more severe pain take \_\_\_\_\_
- \_\_\_\_\_ Do not remove your splint
- \_\_\_\_\_ Do not get your splint wet
- \_\_\_\_\_ See your doctor/clinic immediately or go to the Emergency Department if fingers or toes below your injury become blue, cold, painful or numb
- \_\_\_\_\_ Use crutches \_\_\_\_\_ no weight bearing
- \_\_\_\_\_ Partial weight bearing until you are seen for follow-up
- \_\_\_\_\_ Use an ACE (elastic support) bandage and re-wrap every eight hours for \_\_\_\_\_ days

**EYE INJURIES and INFECTIONS**

- \_\_\_\_\_ For injuries apply an ice pack to reduce swelling
- \_\_\_\_\_ For infections use warm compresses for 5 minutes four times a day. Wash hands after touching the affected eye.
- \_\_\_\_\_ Use medications as prescribed
- \_\_\_\_\_ Contact your doctor/clinic or go to the Emergency Department for any of the following
- Change in vision or loss of vision
- Increasing pain, redness, or swelling
- Fever
- \_\_\_\_\_ Remove eye patch in 12 hours and begin using eye drops as directed
- \_\_\_\_\_ \*\*DO NOT drive or operate machinery while wearing an eye patch
- \_\_\_\_\_ See your doctor/clinic for follow-up in \_\_\_\_\_ days
- \_\_\_\_\_ Return here for re-check in 24 hours

**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**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**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 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: