McLaren Business Products

McLaren Print System Order

Order No: 70051 Reprint Previous Order No: 6595
Order Date: 2022-05-26
User: Amber Kleekamp
Phone: 9895519951

Ship Location: McLaren Thumb Convenient Care Clinic
1040 S Van Dyke Rd
Bad Axe, MI 48413
Forms
Quantity: 500
Paragon Dept No: 54604
Dept Name: McLaren Thumb Elkton Clinic
Company Number: 185

Order Total Price: 282.25

Item Number: MM-34488-B
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: None
Drill: None
Misc Info:

MCLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER
PATIENT DISCHARGE INSTRUCTIONS

TIME IN _____ TIME OUT _____

VOMITING

DIARRHEA

GYNECOLOGICAL PROBLEMS

ELEVATED BLOOD PRESSURE

OTHER CONDITIONS

OCCUPATIONAL MEDICINE
FIRST AID/ER 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 (mo/day)

____ Bending ____ Prolonged sitting
____ Squatting ____ Prolonged standing
____ Reaching ____ Pushing and pulling
____ Kneeling ____ Right handed work
____ Driving ____ Left handed work
____ Climbing ____ Patient on crutches
____ Walking ____ Overtime exposure
____ Lifting
____ Other
____ Lifting restriction of _____ pounds

____ Patient is on total disability

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

OM employees should report to their OM 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 DISCHARGE INSTRUCTIONS

Patient Name

Date of Birth