McLaren Business Products

McLaren Print System Order

Order No: 70667 Reprint Previous Order No: 6595
Order Date: 2022-06-23
User: Kristin Fudge
Phone: 12315821515

Ship Location: McLaren MedCenter Boyne City
1249 M-75
Boyne City, mi 49712
Forms
Quantity: 100
Paragon Dept No: 50726
Dept Name: McLaren MedCenter Boyne City
Company Number: 810

Order Total Price: 56.45

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/LOST 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

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