McLaren Business Products

McLaren Print System Order

Order No: 70668 Reprint Previous Order No: 6597
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-C
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

TIME IN _____ TIME OUT _____

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 (Inclds):

_____ Bending
_____ Squatting
_____ Reaching
_____ Kneeling
_____ Driving
_____ Climbing
_____ Walking
_____ Lifting
_____ Other
_____ Lifting restriction of _____ pounds

_____ Prolonged sitting
_____ Prolonged standing
_____ Pushing and pulling
_____ Right handed work
_____ Left handed work
_____ Patient on crutches
_____ Dust/fumes exposure

_____ 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

_____ PRINT

ID PHYSICIAN'S NAME

NECK and BACK PAIN

_____ Go to the Emergency Department immediately for any of the following
- Loss of bladder or bowel control
- Numbness in arms, legs, hands or feet
- Weakness in arms, legs, hands or feet
- Fever or headache
- Abdominal pain
- Sudden, severe increase in pain

_____ Rest in comfortable position for two days
_____ Use local heat and warm tub soaks for comfort
_____ Back exercises as prescribed when acute pain is lessened
_____ Soft cervical collar for comfort
_____ Take medications as directed
_____ See your doctor or clinic within 3 days for follow up

HEAD INJURIES and HEADACHES

_____ Go to the Emergency Department immediately for any of the following
- Sudden change in behavior/vision
- Sudden development or worsening of headache
- Vomiting
- Confusion and/or disorientation
- Trouble walking

*Awaken sleeping patients every 2-3 hours to check for the above changes

_____ No alcohol
_____ Take medications as ordered
_____ No driving, or dangerous activity until approved by your doctor/clinic
_____ See your doctor/clinic within 3 days for follow up
_____ Ice/cold for discomfort per package instructions
_____ Ibuprofen for discomfort per package instructions

CHEST PAIN

_____ Go to nearest Emergency Department for any of the following
- Worsening pain
- Radiation of pain into neck, jaw or arms
- Nausea and/or vomiting
- Shortness of breath
- Sweats

_____ See your doctor within 3 days for follow up
_____ Do not smoke
_____ Take medications as directed

ABDOMINAL PAIN

_____ Contact your doctor or go to the Emergency Department for any of the following
- Pain worsens or changes location
- Vomiting develops
- Fever develops
- Abdomen swells
- Blood in vomit, urine, or stool
- You stop passing gas or stool
- You become faint or weak

_____ Any new and/or severe abdominal pain that does not improve or resolve within 6 hours should be re-evaluated by your doc- or Emergency Department

for
_____ Clear liquid diet until pain resolves
_____ Take medications as ordered
_____ See your doctor/clinic within 3 days for follow up

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