

McLaren Print System Order

Order No: 72368 Reprint Previous Order No: 6599
Order Date: 2022-09-14
User: Kristin Fudge
Phone: 9897731166

Ship Location: McLaren Central COMP and ReadyCare
1523 S. Mission Street
Mount Pleasant, mi 48858

Forms

Quantity: 500
Paragon Dept No: 50664
Dept Name: McLaren Central COMP and ReadyCare
Company Number: 810

Order Total Price: 96.00

Item Number: MM-34488-D
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: 2 Hole Top
Misc Info:

MCLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER
INPATIENT DISCHARGE INSTRUCTIONS

PRINT ORDER

TIME IN _____ TIME OUT _____

| | |
|---|---|
| <p>WOUNDS</p> <ul style="list-style-type: none"> See your doctor/clinic or go to the Emergency Department for any of the following: <ul style="list-style-type: none"> - Signs of infection (redness, swelling, pain, pain, fever and/or chills) - Bleeding - Numbness, tingling, or weakness of the hand/foot Request for occupational care discharge instructions See 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/discharge as instructed Protect wound with a clean dressing or band-aid as needed Your physician/occupational care specialist may Have additional instructions for Your wound/dressings or return here for a wound check if You <p>SPRAINS, STRAINS, BRUISES and FRACTURES</p> <ul style="list-style-type: none"> 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 Request for occupational care discharge instructions Request for occupational care discharge instructions Do not remove your splint Do not get your splint wet See your doctor/clinic, immediately or go to the Emergency Department if Begins or feels better your hand/before that, cold, numb or tingly Red, swollen, or Painful weight bearing and you are unable to tolerate it Use an ACE bandage to support bandage and to wrap hand/leg Return here for recheck in 3-5 days <p>DRUGS AND PRESCRIPTIONS</p> <ul style="list-style-type: none"> For further apply on the pack to reduce swelling For infections and open wounds for 3 minutes four times a day. Wash hands after handling the affected area See medications as prescribed Contact your doctor/clinic or go to the Emergency Department if any of the following: <ul style="list-style-type: none"> - Change in color or loss of vision - Increasing pain, redness, or swelling - Fever Medication is used in 15 minutes and/or using your discharge Do NOT drive or operate machinery while wearing an eye patch See your doctor/clinic for follow-up if Return here for recheck in 3-5 days | <p>OCCUPATIONAL MEDICINE</p> <p>POST EXPOSURE - 24 Hours to acute distribution</p> <p>Company Name: _____</p> <p>Treatment: _____</p> <p>Condition is: <input type="checkbox"/> Skin related <input type="checkbox"/> Not skin related</p> <p>Refer to Physician/Doc: _____</p> <p>_____ When appointment to be seen in _____ Day</p> <p>_____ Return here for follow-up: Day _____</p> <p>_____ Day _____</p> <p>Patient may return to regular work/activities _____</p> <p>_____ Today _____ Date _____</p> <p>_____ Pending further evaluation and treatment as scheduled above</p> <p>Patient may return to restricted work on _____</p> <p>Work restrictions include the following:</p> <ul style="list-style-type: none"> Lifting _____ Reaching _____ Pushing _____ Pulling _____ Climbing _____ Digging _____ Carrying _____ Standing _____ Lifting _____ Other _____ Other _____ <p>_____ Patient is on total disability</p> <p>Employer should give this information to their supervisor as soon as possible</p> <p>DR employees should report to their DR Medical Department with the information within 30 days</p> <p>DATE/TIME _____</p> <p>PRESCRIPTIONS and OTHER INSTRUCTIONS</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|---|---|

PATIENT'S SIGNATURE _____ DATE/TIME _____

DR PHYSICIAN'S SIGNATURE _____

IMPORTANT NOTE:
With the exception of Occupational Care visits, this center is intended to provide expedient 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. DR encourage you to report this information to your doctor/clinic and follow up with your doctor/clinic as directed.

I was given the opportunity to ask questions and 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 the instruction sheet to that provider, as instructed.

PATIENT'S SIGNATURE _____ DATE _____

WENT'S Employee (mark related visit only)
1000 CMC Medical Records
Print, Patient

see order 6/26/19

INPATIENT DISCHARGE INSTRUCTIONS