

McLaren Print System Order

Order No: 80405 Reprint Previous Order No: 6599
Order Date: 2023-10-11
User: Wendy Langworthy
Phone: 989-779-5240

Ship Location: McLaren Central Occupational health and ReadyCare
1523 S. Mission
Mt. Pleasant, MI 48858

Forms
Quantity: 100
Paragon Dept No: 50664
Dept Name: Practice Management
Company Number: 810

Order Total Price: 18.95

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: None
Misc Info:

McLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER
INPATIENT DISCHARGE INSTRUCTIONS

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, pain, pus, fever and/or chills)
 - Swelling
 - Numbness, tingling, or weakness of the hand/foot
- Report for discharge your discharge instructions
- See medications as directed
- Keep the wound clean and dry
- Cover the wound with a sterile (Gauze & PAD) with or without a full cast or splint and high medical adhesive
- Apply antibiotic ointment (directions on label)
- Protect wound with a loose bandage or band that is needed
- Your discharge instructions may contain other
- There is/are additional(s) _____
- See your doctor/clinic or return here for a wound check in _____

SPRAINS, STRAINS, BRUISES and FRACTURES

- Wear the splint cast for 7-10 days
- Go back to the hospital area for the first 12 hours and then as needed to reduce swelling
- Report for discharge your discharge instructions
- See medications as directed
- Do not remove cast/wound
- Do not get your splint wet
- See your doctor/clinic, emergency or go to the Emergency Department if
- Signs or have fallen your hand because that, cast, splint or hand is/are cast/wound _____
- Apply weight bearing and you are seen for swelling or
- See an MD please support bandage and/or wrap hand/leg
- Return here for a check in 3-5 days

DRUG RESISTANCE AND RESISTANCE

- Do not take any of the pills to reduce swelling
- For infections and pain medications for 3 minutes four times a day. Read labels after receiving the affected area
- See medications as directed
- Report 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
- Report your doctor/clinic or 11 hours and high using your discharge instructions
- DO NOT drive or operate machinery while wearing an eye patch
- See your doctor/clinic for follow up _____
- Return here for a check in 3-5 days

IMPORTANT NOTE

With the exception of Occupational Care visits, this center is intended to provide specific 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 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 _____

HEALTH CARE PROVIDER'S SIGNATURE _____ DATE _____

HEALTH CARE PROVIDER'S NAME _____

HEALTH CARE PROVIDER'S TITLE _____

HEALTH CARE PROVIDER'S PHONE NUMBER _____

HEALTH CARE PROVIDER'S ADDRESS _____

HEALTH CARE PROVIDER'S CITY _____ STATE _____ ZIP _____

HEALTH CARE PROVIDER'S FAX NUMBER _____

HEALTH CARE PROVIDER'S EMAIL ADDRESS _____

HEALTH CARE PROVIDER'S WEBSITE _____

HEALTH CARE PROVIDER'S SOCIAL MEDIA _____

HEALTH CARE PROVIDER'S OTHER INFORMATION _____

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