McLaren Business Products

**McLaren Print System Order**

**Order No: 80771**
**Order Date: 2023-10-30**
**User: Amber  Kleekamp**
**Phone: 9895519951**

**Ship Location:  McLaren Thumb Occupational Health**
**1040 S. Van Dyke Rd**
**Bad Axe, MI 48413**
**Forms**
**Quantity: 500**
**Paragon Dept No: 54604**
**Dept Name: McLaren Thumb Occupational Health**
**Company Number: 530**

**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**
**Poster:**
**Misc Info:**

MCLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER
PATIENT DISCHARGE INSTRUCTIONS

TIME IN _____ TIME OUT _____

VOMITING

DIARRHEA

GYNECOLOGICAL PROBLEMS

ELEVATED BLOOD PRESSURE

OCCUPATIONAL MEDICINE
FIRST AILLIAY 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 (line/day)

____ Bending
____ Squatting
____ Reaching
____ 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/fume exposure

____ Patient is on total disability

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

*OM employee 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

PATIENT'S SIGNATURE DATE

WHITE: Employee (work related visits only)
YELLOW: Medical Records
PINK: Patient

PATIENT DISCHARGE INSTRUCTIONS

**Spec Info:**