

McLaren Print System Order

Order No: 81279 Reprint Previous Order No: 6599
Order Date: 2023-11-27
User: Jennifer Wheeler
Phone: 9897795625

Ship Location: McLaren Central Michigan -- ATTN:Jennifer Wheeler
1523 S. Mission St
Mt. Pleasant , MI 48858

Forms

Quantity: 500
Paragon Dept No: 55802
Dept Name: McLaren Central Michigan
Company Number: 810

Order Total Price: 94.75

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

PRINT ORDER

TIME IN _____ TIME OUT _____

WOUNDS

- _____ 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)
 - Bleeding
 - Numbness, tingling, or weakness of the extremity
- _____ Report for observation per discharge instructions
- _____ Take 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 sterile dressing or band that is needed
- _____ Your laboratory information will be mailed to you
- _____ Have someone accompany you _____ days
- _____ See your doctor/clinic or return here for a wound check in _____ days

SPRAINS, STRAINS, BRUISES and FRACTURES

- _____ Evaluate the injured part for 7-10 days
- _____ Ice apply to the injured area for the first 12 hours and then as needed to reduce swelling
- _____ Report for observation per discharge instructions
- _____ Squelch for observation per discharge instructions
- _____ Do not remove cast/wrap
- _____ Do not get your cast/wrap wet
- _____ See your doctor/clinic, immediately or go to the Emergency Department if:
 - Begins or feels better your hours beyond that cast, cast/wrap or bandage is cast/wrap
 - Cast/wrap is too tight or too loose
 - Cast/wrap is broken or damaged and/or is slipping down your limb
 - You are not getting support bandage and/or wrap every night
 - You are _____ days

DRUG RESISTANCE AND RESISTIONS

- _____ Do not take any of the pills to reduce swelling
- _____ For infections and pain medications for 1 minute four times a day. Read labels after receiving the affected area
- _____ Take medications as prescribed
- _____ Contact 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
- _____ Never use alcohol or OTCs and never using any alcohol products
- _____ DO NOT drive or operate machinery while wearing an eye patch
- _____ See your doctor/clinic for follow up in _____ days
- _____ Return here for recheck in 30 days

OCCUPATIONAL MEDICINE

POST EXPOSURE REPORT - Required to receive distribution

Company Name _____

Treatment _____

Condition is _____ With related _____ Not work related _____ (underlined)

Refer to Physician/Doc _____

_____ When appointment to be seen in _____ days

_____ Return here for follow up _____ days _____

Patient may return to regular work/activities _____

_____ Today _____ Date _____

_____ Pending further evaluation and treatment as scheduled above

Patient may return to restricted work on _____

Work restrictions include (check):

- _____ Bending _____ Postural strain
- _____ Reaching _____ Postural standing
- _____ Climbing _____ Pushing and pulling
- _____ Driving _____ Right-handed work
- _____ Lifting _____ Left-handed work
- _____ Walking _____ Patient on crutches
- _____ Lifting _____ Disturbance
- _____ Lifting restriction of _____ pounds

_____ Patient is on total disability

Employee should give this information to their supervisor as soon as possible

DR employees should report to their DR Medical Department with the information within 30 days

DATE/TIME _____

PRESCRIPTIONS and OTHER INSTRUCTIONS

PATIENT'S SIGNATURE _____ DATE/TIME _____

DR PHYSICIAN'S NAME _____

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 _____

WHEELER, Jennifer (work related visit only)
1523 S. Mission St
Mt. Pleasant
MI 48858-0000

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