

McLaren Print System Order

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McLaren
 THUMB REGION ED AFTERCARE INSTRUCTIONS

Your diagnosis is _____

Follow up with Dr. _____ in _____ days. Call as soon as possible to schedule your appointment.

EYES	1) See your medical provider/urgent care ASAP if you begin to have severe pain, or changes of your vision. 2) Rest the area and elevate it above the level of the heart as much as possible. 3) Apply ice to area for 15-20 minutes several times per day for the first 48 hours. (Never apply ice to bare skin.)
SPRAINS STRAINS FRACTURES	4) You should remove and rewrap the elastic bandage twice per day or if it feels too tight. 5) Use crutches & perform weight bearing until able to stand without pain then slowly return to normal activity. 6) <input type="checkbox"/> Crushed Walking Impression Shoe/Boot to Patient 7) Go to urgent care or the ED immediately if the extremity becomes cold, numb, or you have severe pain.
BACK & NECK MUSCLES	1) Rest affected area, avoid painful positions/movements. Gentle firm massage may help relieve soreness. 2) Apply warm compresses or soaks to the affected part for 20-30 minutes 4 times per day. 3) If you experience increased pain or numbness in your arm or legs, go to urgent care or the ED immediately.
HEAD HAZARD	1) Do not use sedatives, narcotic pain killers, or alcohol for 24 hours after the injury. (No contact sports until OK by Dr.) Return to the Emergency Department immediately if any of the following develop: Repeated vomiting or retching, Changes in vision, Severe headache, Headaches, Numbness, Unusual Drowsiness, Difficulty with Balance, Difficulty hearing, Confusion or Disorientation, Unable to move arms or legs, Unequal pupils (back part of eye different sizes). The patient should be evaluated every _____ hours for the first 24 hours.
WOUND CARE	1) Keep wound clean and dry. See your medical provider or go to urgent care if any signs of infection develop (increasing redness, swelling, pain, or the appearance of pus, fever, foul odor, red streaks on the skin). 2) Remove the dressing on _____ days and change it _____ times per day for _____ days. 3) You may cleanse the area around the wound with a mild soap and water and apply antibiotic ointment to the wound itself. 4) Follow up with urgent care or your medical provider for wound checks/culture removal in _____ days.
FEVER PAIN	1) Acetaminophen (Tylenol) _____ every _____ hours with food as needed. 2) Ibuprofen (Advil) _____ every _____ hours as needed. 3) You may alternate the Acetaminophen and Ibuprofen every _____ hours. 4) If the fever is persistent or the patient becomes confused, lethargic (very slow, tired), or has a seizure, return to the Emergency Department immediately.
VOMITING DIZZINESS DIZZINESS DIZZINESS	1) Eat or drink nothing for 4 hours if vomiting is a problem. 2) Clear liquids only the first 24 hours (water, clear juice, weak tea, flat soda, jelly water, clear soup, popsicles). 3) After 24 hours advance to B.R.A.T. diet (Bananas, Rice, Applesauce, and Toast). 4) Avoid fatty, greasy, or spicy foods, milk and milk products. After 48 hours you may return to your normal diet.
GENERAL	1) Do not return to work or school until you are able to perform your normal activities. 2) Do not return to work or school until you are able to perform your normal activities. 3) Do not return to work or school until you are able to perform your normal activities. 4) Do not return to work or school until you are able to perform your normal activities. 5) Do not return to work or school until you are able to perform your normal activities. 6) Do not return to work or school until you are able to perform your normal activities. 7) Do not return to work or school until you are able to perform your normal activities. 8) Do not return to work or school until you are able to perform your normal activities. 9) Do not return to work or school until you are able to perform your normal activities. 10) Do not return to work or school until you are able to perform your normal activities.
Medications	1) Continue Your Present Home Medications as Before: _____ (Medications) 2) Stop taking: _____ (Medications) 3) Add These Medications: _____ (Medications)
Procedures & Tests Performed	1) Lab Work: _____ (Tests) 2) X-Ray: _____ (Tests) 3) Ultrasound: _____ (Tests) 4) Other: _____ (Tests)
Other Instructions	1) _____ 2) _____

Patient/Legal Guardian Signature _____ Nurse Signature _____

Date _____ Time _____ Physician Signature _____

PATIENT'S SIGNATURE DENOTES RECEIPT AND UNDERSTANDING OF THE MATERIAL

380 100 05-18

Spec Info: