

McLaren Print System Order

Order No: 22803 Reprint Previous Order No: 6599
Order Date: 2016-10-24
User: Krystal Chittle
Phone: 810-667-7040

Ship Location: MCLAREN OCCUPATIONAL HEALTH (KNOLLWOOD CLINIC)
1254 N MAIN ST
LAPEER, MI 48446

Forms
Quantity: 500
Paragon Dept No: 65100
Dept Name: McLaren Occupational Health
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: 6/2016
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
PATIENT DISCHARGE INSTRUCTIONS

Phone: 1-800-667-7040, Main St., Lapeer, MI 48446 810-667-7040
 Fax: 810-667-7040, Main St., Lapeer, MI 48446 810-667-7040
 Location: 1254 N Main St., Lapeer, MI 48446 810-667-7040

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, heat, fever and/or chills)
 _____ Bleeding
 _____ Numbness, tingling, or weakness of the hand/arm
 _____ Report for dressing or coverage instructions
 _____ Report for dressing or coverage instructions
 _____ Report for dressing or coverage instructions
 _____ Keep the wound clean and dry
 _____ Cover the wound with tape (1" x 2" or 1 1/2" x 1 1/2") with a piece of half inch wide and half inch long gauze
 _____ Apply antibiotic ointment (do not use petroleum)
 _____ Change dressing with a sterile dressing or band-aid as needed
 _____ Use sterile instructions for dressing only
 _____ Wash hands thoroughly with soap and water
 _____ See your doctor/clinic or report back for a wound check in _____ days

SPRAINS, STRAINS, BRUISES and FRACTURES
 _____ 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
 _____ Report for dressing or coverage instructions
 _____ Report for dressing or coverage instructions
 _____ Do not move your joint
 _____ Do not get your joint wet
 _____ See your doctor/clinic immediately or go to the Emergency Department if:
 _____ Pain or tenderness (your hand, forearm, wrist, elbow or hand)
 _____ Swelling
 _____ No weight bearing
 _____ Pain or weight bearing will not ease after 48 hours or
 _____ You or a caregiver cannot lift or move the injured part
 _____ Report _____ days

EYE INJURIES and IRRITATIONS
 _____ Do not touch eyes or do not rub to reduce swelling
 _____ For irritation use warm compresses for 5 minutes four times a day. Wash hands after handling the affected eye.
 _____ Use 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
 _____ Vision obscured in 12 hours and high using eye drops
 _____ Report _____ days
 _____ Report _____ days or update treatment while waiting or on your path
 _____ See your doctor/clinic for follow up in _____ days
 _____ Return here for to obtain instructions

IMPORTANT NOTE
 With the exception of Occupational Care visits, this center is intended to provide episodic 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 have given the opportunity to ask questions and understand the instructions given to me. I hereby acknowledge receipt of the instructions above and realize that it may be revised before all of my medical problems are treated. I will arrange for follow-up care and provide the instruction sheet to that provider as instructed.

PATIENT'S SIGNATURE _____ **DATE** _____

WITNESS: (Employee bears witness only) _____
YELLOW: (Medical Records) _____
PINK: Patient _____

PATIENT DISCHARGE INSTRUCTIONS

PHYSICIAN'S SIGNATURE _____ **DATE/TIME** _____

NURSE'S SIGNATURE _____ **DATE/TIME** _____

PRESCRIPTIONS AND OTHER INSTRUCTIONS

PRESCRIPTIONS

OTHER INSTRUCTIONS

WORK RESTRICTIONS

WORK RESTRICTIONS (IF APPLICABLE)

PATIENT'S SIGNATURE _____ **DATE** _____

WITNESS: (Employee bears witness only) _____
YELLOW: (Medical Records) _____
PINK: Patient _____

PATIENT DISCHARGE INSTRUCTIONS