McLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER
PATIENT DISCHARGE INSTRUCTIONS

Please Check Location:
- ❑ 1254 N, Main St., Lapeer, MI 48446 (810) 667-7040
- ❑ 1523 S. Mission St., Mt. Pleasant, MI 48858 (989) 779-5600
- ❑ 1523 S. Mission St., Suite 2, Mt. Pleasant, MI 48858 (989) 773-1166
- ❑ 2313 E. Hill Rd., Grand Blanc, MI 48439 (810) 496-0900
- ❑ 6910 S. Cedar St., Lansing, MI 48911 (517) 975-3110

OFFICE STAMP

McLaren Redi Care South - Lansing
6910 South Cedar Street
Lansing, MI 48911
(517) 975-3110

RESPIRATORY INFECTIONS

_____ Increase fluids and rest
_____ Take medications as prescribed
_____ Tylenol for fever/discomfort per package instructions
_____ Ibuprofen for fever/discomfort per package instructions
_____ See your doctor/clinic or return here if worsening
_____ Room humidifier, saline nose drops/spray and gargles may make you more comfortable
_____ Do not smoke; avoid second hand smoke

***Antibiotics are not prescribed for viral illness as they are not effective against viral infections and may complicate your care if your condition changes.

ALLERGIC REACTIONS and STINGS

_____ Go to the Emergency Department immediately if any of the following develop:
- Shortness of breath and/or wheezing
- Throat tightness
- Difficulty swallowing
- Swelling of lips and/or tongue
- Worsening of rash and/or hives

_____ Take medications as prescribed
_____ See your doctor/clinic within 3 days for follow up
_____ Avoid further exposure to allergic agent

***Some medications used to treat these conditions cause drowsiness. You should not drive or operate machinery when taking these medications.

FEVER

_____ Take medications as directed
_____ Increase fluids
_____ Rest and avoid exertion while febrile
_____ Tylenol fever control per package instructions
_____ Ibuprofen fever control per package instructions
_____ Contact your doctor or go to the Emergency Department for any of the following:
- Worsening or change in symptoms
- Shaking chills
- Uncontrolled fever

_____ See your doctor/clinic within 3 days for follow up
_____ For children:
- For babies up to 4 months of age – go directly to your doctor/clinic or the Emergency Department for a rectal temperature of 100.5° F or greater
- DO NOT give aspirin or aspirin products to children less than 16 years of age
- Sponging and tepid baths may make the fever worse by causing shivering

INFECTIONS

_____ Take medications as prescribed
_____ Tylenol for fever and/or discomfort per package instructions
_____ Ibuprofen for fever and/or discomfort per package instructions
_____ For **throat infections** salt water gargles every 4 hours and chloraseptic spray may ease your discomfort
_____ For **outer ear infections** avoid getting any water in the affected ear for ten days
_____ For **urinary tract infections** urinate at least every 2 hours while awake and take three 8 oz glasses of cranberry juice per day unless diabetic
_____ For **skin and wound infections** clean the affected area twice a day and apply bacitracin ointment
_____ See your doctor/clinic within 7 days for follow up
_____ Frequent handwashing

TIME IN: _____ TIME OUT: _____

_____ Do not smoke/avoid second hand smoking
_____ Do not drink alcohol while taking antibiotics

OCCUPATIONAL MEDICINE
FIRST INJURY 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 (hrs/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.

GM employees should report to their GM Medical Department with this information within 24 hours.

DIAGNOSIS _____

PRESCRIPTIONS and OTHER INSTRUCTIONS

_____
_____
_____

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

_____
PRINTED PHYSICIAN'S NAME

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 intervention to your doctor/clinic and follow up with your doctor/clinic as directed.

I was given the opportunity to ask questions and I 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 this instruction sheet to that provider as instructed.

_____
PATIENT'S SIGNATURE **DATE**

WHITE: Patient
YELLOW: Employer (work-related visits only)
PINK: Medical Record

Patient Name:

Date of Birth: