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

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, pus, pain, fever and/or chills)
- Bleeding
- Numbness, tingling, or weakness of the injured part

_____ Tylenol for discomfort per package instructions
_____ Ibuprofen for discomfort per package 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 (bacitracin) as instructed
_____ Protect wound with a loose bandage or Band-Aid as needed
_____ Your tetanus immunization was updated today
_____ Have sutures removed in _____ days
_____ See your doctor/clinic or return here 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
_____ Tylenol for discomfort per package instructions
_____ Ibuprofen for discomfort per package instructions
_____ For more severe pain take _____
_____ Do not remove your splint
_____ Do not get your splint wet
_____ See your doctor/clinic immediately or go to the Emergency Department if fingers or toes below your injury become blue, cold, painful or numb
_____ Use crutches _____ no weight bearing
_____ Partial weight bearing until you are seen for follow-up
_____ Use an ACE (elastic support) bandage and re-wrap every eight hours for _____ days

EYE INJURIES and INFECTIONS

_____ For injuries apply an ice pack to reduce swelling
_____ For infections use warm compresses for 5 minutes four times a day. Wash hands after touching 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
- Fever

_____ Remove eye patch in 12 hours and begin using eye drops as directed
**DO NOT drive or operate machinery while wearing an eye patch
_____ See your doctor/clinic for follow-up in _____days
_____ Return here for re-check in 24 hours

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	_____ Prolonged sitting
_____ Squatting	_____ Prolonged standing
_____ Reaching	_____ Pushing and pulling
_____ Driving	_____ Right handed work
_____ Climbing	_____ Left handed work
_____ Walking	_____ Patient on crutches
_____ Lifting	_____ Dust/fume exposure
_____ Other	

_____ Lifting restriction of _____ pounds

_____ 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:

MM-34488-D (Rev. 10/14)

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