

**McLaren Print System Order**

**Order No: 48197 Reprint Previous Order No: 6597**  
**Order Date: 2019-08-29**  
**User: Kelly Lewis**  
**Phone: 810-496-0916**

**Ship Location: Midland Occupational and Convenient Care**  
**801 Joe Mann Blvd.**  
**Midland, MI 48642**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 560062**  
**Dept Name: Midland Occupational and Convenient Care**  
**Company Number: 810**

**Order Total Price: 96.00**

**Item Number: MM-34488-C**  
**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: 5 Hole Top**  
**Misc Info:**

MCLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER  
INPATIENT DISCHARGE INSTRUCTIONS

PRINT ORDER

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**NECK AND BACK PAIN**

Go to the Emergency Department immediately for any of the following:

- Loss of bladder or bowel control
- Numbness in arms, legs, hands or feet
- Weakness in arms, legs, hands or feet
- Fever or headache
- Abnormal gait
- Swollen, redness or pain
- Stiff or uncomfortable position for neck sleep
- Low back pain and pain felt inside the chest
- Sharp, persistent pain when lying down in bed
- Loss of sensation in arms or legs
- Loss of sensation in chest
- Use your doctor or clinic within 2 days for follow up

**HEAD PAIN**

Go to the Emergency Department immediately for any of the following:

- Sudden change in vision/blurred
- Sudden development or worsening of headache
- Double vision or diplopia
- Swelling
- Headache waking patients every 2-3 hours to check for the above changes
- No swelling
- New medications as ordered
- No change or improvement within 2 days for follow up
- Use your doctor or clinic within 2 days for follow up
- Use your doctor or clinic within 2 days for follow up
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**CHEST PAIN**

Go to the Emergency Department for any of the following:

- Swelling pain
- Redness of pain into neck, jaw or arms
- Redness or swelling
- Swelling of feet
- Use your doctor within 2 days for follow up
- Use your doctor within 2 days for follow up
- Use your doctor within 2 days for follow up

**RECOVERY PAIN**

Contact your doctor or go to the Emergency Department for any of the following:

- Pain increases or changes location
- Swelling develops
- Fever develops
- Medication stops
- Blurred or double vision or diplopia
- No pain within 2 days for follow up
- No swelling within 2 days for follow up
- No swelling within 2 days for follow up

**SEE**

- Check Report or Test with Physician
- Use medications as ordered
- Use your doctor within 2 days for follow up

**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 episodic 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 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** \_\_\_\_\_

WENT: Employee (mark initial with only)  
MID: Occupational Health/Convenient Care  
PHYS: Physician  
See order in file #116

**INPATIENT DISCHARGE INSTRUCTIONS**

**TIME IN** \_\_\_\_\_ **TIME OUT** \_\_\_\_\_

**OCCUPATIONAL MEDICINE**  
**FIRST AID/REPORT - RETURN TO WORK EMPLOYER**

Company Name: \_\_\_\_\_  
Treatment: \_\_\_\_\_  
Condition:  Work-related  Not work-related  
 Undetermined

Refer to Physician/Physician Assistant: \_\_\_\_\_  
Make appointment to be seen in:  Work  Home  
Return here for follow up:  Yes  No

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):  
 Lifting  Pushing  Prolonged standing  
 Reaching  Climbing  Pushing and pulling  
 Driving  Night/shift work  
 Working  Self-handled work  
 Lifting  Patient or employee  
 Other \_\_\_\_\_  
 Lifting restriction of \_\_\_\_\_ pounds

Patient is on total disability

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

Our employees should report to their HR/Medical Department with this information within 24 hours.

**DIAGNOSIS** \_\_\_\_\_

**PRESCRIPTIONS and OTHER INSTRUCTIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **DATE/TIME** \_\_\_\_\_

**ED PHYSICIAN'S NAME** \_\_\_\_\_ **PRINT**