

**McLaren Print System Order**

**Order No: 48692 Reprint Previous Order No: 6599**  
**Order Date: 2019-09-18**  
**User: Theda Simmonds**  
**Phone: 989-393-2857**

**Ship Location: McLaren Occupational and Convenient Care - Bay City**  
**4 Columbus Ave**  
**Bay City, MI. 48708,**

**Forms**

**Quantity: 2500**  
**Paragon Dept No: 69100**  
**Dept Name: Occupational Convenient Care**  
**Company Number: 810**

**Order Total Price: 453.00**

**Item Number: MM-34488-D**  
**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: None**  
**Misc Info:**

PRINT ORDER

**MCLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER**  
**PATIENT DISCHARGE INSTRUCTIONS**

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, pus, fever and/or chills)
- \_\_\_\_\_ Bandaging
  - Cleanliness, drying, or moisture of the wound/spot
  - Support for absorption of drainage/instructions
- \_\_\_\_\_ Support for absorption of drainage/instructions
- \_\_\_\_\_ Dressing instructions as directed
- \_\_\_\_\_ Change the wound twice daily (AM & PM) with or without a half cup water and half teaspoon antibiotic
- \_\_\_\_\_ Apply antibiotic ointment/dressings as instructed
- \_\_\_\_\_ Protect wound with a cover/dressing or band if not needed
- \_\_\_\_\_ Your infection/instruction may require daily
- \_\_\_\_\_ Have antibiotic ointment for \_\_\_\_\_ days
- \_\_\_\_\_ Stop your antibiotics or return here for a wound check if \_\_\_\_\_ days

**SPRAINS, STRAINS, BRUISES and FRACTURES**

- \_\_\_\_\_ Evaluate the injured part for 7-10 days
- \_\_\_\_\_ Ice apply to the injured area for the first 12 hours and then as needed to reduce swelling
- \_\_\_\_\_ Support for absorption of drainage/instructions
- \_\_\_\_\_ Support for absorption of drainage/instructions
- \_\_\_\_\_ Do not remove cast/wrap
- \_\_\_\_\_ Do not get your cast/wrap wet
- \_\_\_\_\_ See your doctor/clinic, emergency or go to the Emergency Department if:
  - Begins or has been pain your injury (aching, throbbing, numbness or tingling)
  - Cast/wrap is \_\_\_\_\_
  - Painful weight bearing and you are unable to tolerate it
  - You are not getting support/bandage and/or wrap every eight hours for \_\_\_\_\_ days

**ORF (FINGER) AND REFLECTIONS**

- \_\_\_\_\_ For hygiene apply to the patch to reduce swelling
- \_\_\_\_\_ For infections and open sores/compression for 1 minute four times a day. Wash hands after touching the affected area
- \_\_\_\_\_ Dressing/instructions as prescribed
- \_\_\_\_\_ Contact your doctor/clinic or go to the Emergency Department for any of the following:
  - Change in color or loss of shape
  - Increasing pain, redness, or swelling
  - Fever
- \_\_\_\_\_ Remain on cast for 10 days and begin using your drainage device
- \_\_\_\_\_ DO NOT drive or operate machinery while wearing an eye patch
- \_\_\_\_\_ See your doctor/clinic for follow-up at \_\_\_\_\_ days
- \_\_\_\_\_ Return here for recheck in 30 days

**OCCUPATIONAL MEDICINE**

**PROFESSOR REPORT - REQUIRED TO BE FILLABLE**

Company Name \_\_\_\_\_

Treatment \_\_\_\_\_

Condition is \_\_\_\_\_ Work-related \_\_\_\_\_ Not work-related \_\_\_\_\_

Refer to Physician/Date \_\_\_\_\_

\_\_\_\_\_ When appointment to be seen at \_\_\_\_\_ day

\_\_\_\_\_ Return here for follow-up \_\_\_\_\_ Day

Patient may return to regular work/activities \_\_\_\_\_ Day

\_\_\_\_\_ Pending further evaluation and treatment as scheduled above

Patient may return to restricted work on \_\_\_\_\_

Work restrictions include (check):  
 Lifting \_\_\_\_\_  Pushing/pulling \_\_\_\_\_  
 Bending \_\_\_\_\_  Prolonged standing \_\_\_\_\_  
 Reaching \_\_\_\_\_  Running and jostling \_\_\_\_\_  
 Climbing \_\_\_\_\_  Night/shift work \_\_\_\_\_  
 Driving \_\_\_\_\_  Call handling work \_\_\_\_\_  
 Stairing \_\_\_\_\_  Patient or customer \_\_\_\_\_  
 Lifting \_\_\_\_\_  Disturbance \_\_\_\_\_  
 Heavy restriction of \_\_\_\_\_ pounds

\_\_\_\_\_ Patient is on total disability

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

DR employees should report to their DR Medical Department with the information within 30 days

DATE/TIME \_\_\_\_\_

**PRESCRIPTIONS and OTHER INSTRUCTIONS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PATIENT'S SIGNATURE \_\_\_\_\_ DATE/TIME \_\_\_\_\_

DR PHYSICIAN'S SIGNATURE \_\_\_\_\_

**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. DR 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 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 (work-related visits only)  
WENT: DR Medical Records  
Print: Patient

see inside of box at the bottom of this page

**PATIENT DISCHARGE INSTRUCTIONS**