

McLaren Print System Order

Order No: 53310 Reprint Previous Order No: 6599
Order Date: 2020-03-12
User: Shannon Pierce
Phone: 810-667-7040

Ship Location: Lapeer Occupational and Convenient Care
1254 S Main St
Lapeer, MI 48446

Forms
Quantity: 100
Paragon Dept No: 65100
Dept Name: Lapeer Occupational and Convenient Care
Company Number: 810

Order Total Price: 18.95

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:

McLAREN OCCUPATIONAL HEALTH/CONVENIENT CARE CENTER
PATIENT DISCHARGE INSTRUCTIONS

TIME IN _____ TIME OUT _____

WOUNDS

- 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)
 - Bleeding
 - Numbness, tingling, or weakness of the hand/foot
- Report for absorption or coverage instructions
- See medications as directed
- Keep the wound clean and dry
- Cover the wound here only (DIP & PIP) with a sterile of half inch water and high moisture adhesive
- Apply antibiotic ointment (directions on label)
- Protect wound with a loose bandage or band-aid as needed
- Your infection instructions may include using:
 - Warm soaks (directions on label)
 - Hot or cold compresses or heat packs for a wound that is:
 - Pain
 - Itchy

SPRAINS, STRAINS, BRUISES and FRACTURES

- Wear the splint part for 7-10 days
- Go back to the hospital area for the first 12 hours and then as needed to reduce swelling
- Report for absorption or coverage instructions
- See medications as directed
- Do not remove cast until:
 - You are seen by your doctor
 - Do not get your splint wet
- See your doctor/clinic, immediately or go to the Emergency Department if:
 - Begins or feels better your hand/foot/ankle/leg, cast, splint or bandage is rubbing
 - Painful weight bearing and you are seen for swelling or
 - You are not getting support bandage and/or wrap every night
 - Swelling

DRUGS AND INSTRUCTIONS

- For home use on the back to reduce swelling
- For infections and open wounds for 1 minute four times a day. Wash hands after handling the affected area
- See medications as directed
- Report your symptoms or go to the Emergency Department if any of the following:
 - Change in color or loss of vision
 - Increasing pain, redness, or swelling
 - Fever
- Report on contact or 15 minutes and high using for drainage (directions)
- DO NOT drive or operate machinery while wearing an eye patch
- See your doctor/clinic for follow-up
- Return here for recheck in 3-5 days

OCCUPATIONAL MEDICINE

POST SURGICAL - Applies to acute distribution

Company Name _____

Treatment _____

Condition is _____ With related _____ Not work related _____

Refer to Physician/Doc _____

_____ When appointment to be seen in _____ Day _____

_____ Return here for follow-up _____ Day _____

_____ Time _____

Patient may return to regular work/activities _____

_____ Today _____ Date _____

_____ Pending further evaluation and treatment as scheduled above

Patient may return to restricted work or _____

Work restrictions include the following:

- _____ Bending _____ Postural sitting
- _____ Reaching _____ Postural standing
- _____ Carrying _____ Pushing and pulling
- _____ Climbing _____ Right-handed work
- _____ Lifting _____ Left-handed work
- _____ Walking _____ Patient on crutches
- _____ Lifting _____ Drive/operate equipment
- _____ Lifting 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 when in-leave

DATE/TIME _____

PRESCRIPTIONS and OTHER INSTRUCTIONS

PATIENT'S SIGNATURE _____ DATE/TIME _____

DR PHYSICIAN'S NAME _____

IMPORTANT NOTE

With the exception of Occupational Care visits, this center is intended to provide acute care for your convenience. The examination and treatment that you have received has been in an occupational care facility 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 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 _____

WENTZ Employment (work-related visits only)
1000 Oak Medical Records
Pleasant, Michigan
800-667-7040

PATIENT DISCHARGE INSTRUCTIONS