

McLaren Print System Order

Order No: 59494
 Order Date: 2021-01-07
 User: Tim Zurek
 Phone: 9892699521

Ship Location: McLaren Thumb Region Emergency Room Attn: Tim
 1100 S. Van Dyke Rd.
 Bad Axe, MI 48731

Forms
 Quantity: 100
 Paragon Dept No: 060
 Dept Name: Emergency Room
 Company Number: 530

Order Total Price: 8.76

Item Number: 6230-167
 Item Description: ER Chest Pain
 Revision Date: 07/2018
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Misc Info: ds; 2 pages-Tumbled; black; bond stapled in corner

Spec Info:

McLaren McLaren Thumb Region
 1100 S. Van Dyke
 Bad Axe, MI 48731 or 989-269-9521
EMERGENCY PHYSICIAN RECORD
 - Chest Pain -

DATE: _____ TIME: _____ ROOM: _____ RN: _____
 NARRATIVE FROM: Emergency Room Transfer from
 TREATMENT PLAN by patient paramedic: EP NP
 acute symptoms: less altered status
 HISTORY: present, acute, paramedic, _____

 order to admit

HPI
 Chief Complaint: chest pain / discomfort
 Onset: _____
 Location: _____
 Quality: _____
 Severity: _____
 Associated symptoms: _____
 Aggravating factors: _____
 Relieving factors: _____
 Physical Exam: _____
 Vital Signs: _____
 ECG: _____
 CXR: _____
 Labs: _____
 Imaging: _____
 Other: _____

ROS
 HEENT: _____
 Eyes: _____
 Ears: _____
 Nose: _____
 Throat: _____
 Neck: _____
 Heart: _____
 Lungs: _____
 Abdomen: _____
 Extremities: _____
 Neuro: _____
 Skin: _____
 Genitourinary: _____
 Rectal: _____
 GU: _____
 Endocrine: _____
 Hematologic: _____
 Immune: _____
 Psych: _____
 Complete medical history, all systems above reviewed and found negative

PAST HX
 Hypertension: _____
 Diabetes: _____
 Hyperlipidemia: _____
 COPD: _____
 Asthma: _____
 MI: _____
 Stroke: _____
 Cancer: _____
 Other: _____

Surgical/Procedures
 Cardiac: _____
 Thoracic: _____
 Abdominal: _____
 GU: _____
 Other: _____

SOCIAL HX
 Tobacco: _____
 Alcohol: _____
 Illicit Drugs: _____
 Sexual Activity: _____
 Travel: _____
 Pets: _____

FAMILY HX
 CAD: _____
 Hypertension: _____
 Diabetes: _____
 Stroke: _____
 Cancer: _____
 Other: _____

Order symptoms previously: _____
 Recently seen / treated by doctor / hospitalist: _____
 Date Rec: 01 Page 1 of 1