McLaren Business Products

McLaren Print System Order

Order No: 59769 Reprint Previous Order No: 5261
Order Date: 2021-01-20
User: Cherry Ebi
Phone: 586-412-5117

Ship Location: Northgrove Attn Cherry
44200 Garfield, Ste 164
Clinton Twp, Mi 48038
Forms
Quantity: 100
Paragon Dept No: 72150
Dept Name: McLaren Macomb Northgrove Women
Company Number: 810

Order Total Price: 0.00

Item Number: MM-34
Item Description: IUD Insertion
Revision Date: 8/2013
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

McLaren Ambulatory Care Center
IUD INSERTION

Date: ____________
Phone (Home): ____________ (Work/Cell): ____________
Current Weight: ________ Blood Pressure: ________ Last menstrual period: ________

HISTORY
Pregnancy: ___ Pregnancies ___ Live Births ___ Abortions ___ Miscarriages
Date of Last Delivery: ________
Previous abnormal pap test: ❑ No or ❑ Yes Explain: ____________
History of previous cervical procedure: ❑ No or ❑ Yes Explain: ____________
History of cancer (cervical): ❑ No or ❑ Yes
Smoker: ❑ No or ❑ Yes
History of Venereal Diseases: ❑ No or ❑ Yes
Check boxes that pertain: ❑ Chlamydia ❑ Gonorrhea ❑ Herpes ❑ Syphilis ❑ HIV
Serum pregnancy test: ____________ Pap results: ____________
Vag culture results: ____________ DNA GC/Chlamydia results: ____________
Uterine sound: ____________ Cm
Pelvic/Bimanual Exam (Pre-insertion): ____________

PROCEDURE:
Physician performing procedure
Stock Number: ____________ Type of IUD: ____________

PLAN
1. Patient informed of risk and complications of this procedure including, but not limited to, perforation of the uterus, infections, heavy bleeding and/or cramping. * ________
2. Discourage smoking
3. Encourage monogamous relationship. If relationship changes have cervical cultures redone. May need IUD removed
4. Yearly physical exam
5. Patient to check IUD string placement after each menstrual cycle
6. Call clinic if fever, pelvic pain, abnormal uterine bleeding or missed menses

Date of scheduled removal: ____________

Education/Risk/Benefit Discussed and Information Given * ____________

Patient Signature Date

Witness Date

Provider's Signature Date/Time