

McLaren Print System Order

Order No: 61781
Order Date: 2021-04-19
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: 500
Paragon Dept No: 060
Dept Name: Emergency Room
Company Number: 530

Order Total Price: 117.00

Item Number: MTR-08
Item Description: EMERGENCY DEPART RECORD - PHYSICIAN ORDER SHEET
Revision Date: 6/2019
Print: 1 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info: SS; 2 PART

 1100 S. Van Dyke
Bad Axe, Michigan 48731
(989) 269-9521

EMERGENCY DEPARTMENT RECORD-PHYSICIAN ORDER SHEET

Lab/ Radiology/ Cardio-Pulmonary- See CPCE Orders

<input type="checkbox"/> Nursing Orders <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Orthostatic Vitals <input type="checkbox"/> Foley Cath-Indwelling <input type="checkbox"/> Straight Cath <input type="checkbox"/> NG Tube <input type="checkbox"/> Interm <input type="checkbox"/> Cont <input type="checkbox"/> Wound Care <input type="checkbox"/> (W/Sitem/2) <input type="checkbox"/> Sutures <input type="checkbox"/> NS <input type="checkbox"/> Suture Set up <input type="checkbox"/> Staples <input type="checkbox"/> Dressing <input type="checkbox"/> OBL, Ate Oint <input type="checkbox"/> OOL, Splint Application: <input type="checkbox"/> Ace Wrap <input type="checkbox"/> Crutches <input type="checkbox"/> Walker	<input type="checkbox"/> Knee Immobilizer _____Knee <input type="checkbox"/> Air Cast _____AIRB <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ Consultations - <input type="checkbox"/> Tele-Stroke Q3014 / 6012874 <input type="checkbox"/> Tele-Psychiatry Q3014 / 6012874 <input type="checkbox"/> Tele-Cardiology Q3014 / 6012874 <input type="checkbox"/> Other _____
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Medication Orders
 Stroke Protocol Alteplase (TPA)
 MI Protocol Tenecteplase (TNP)

Nr _____ ml Bolus
Per _____ ml/hr
2nd hr _____ ml/hr

Nursing Signature Initials: _____

Spec Info: _____ Digestive Double Triple Quad Critical
 Isolated Observation Ambulatory (one day surgery) Discharge AMA WBS

Transfer to: _____ Accepting Dr: _____
Physician Signature: _____ Date: _____ Time: _____
Signature: _____ Room # _____ Tech/BN Initials: _____ Date: _____ Time: _____

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