

**McLaren Print System Order**

**Order No: 61813 Reprint Previous Order No: 24893**  
**Order Date: 2021-04-20**  
**User: Lisa Ardanowski**  
**Phone: 810-768-2073**

**Ship Location: McLaren Surgery and Endoscopy Center Attn: Lisa Ardanowski**  
**501 S. Ballenger Hwy**  
**Flint, MI 48532**

**Forms**

**Quantity: 1000**  
**Paragon Dept No: 30014**  
**Dept Name: Surgery and Endoscopy Center Pain Clinic**  
**Company Number: 60**

**Order Total Price: 224.00**

**Item Number: M-17459**  
**Item Description: Implanted\_Extended\_Device\_Record**  
**Revision Date: 12/2016**  
**Print: 1 sided black and white**  
**Paper: 2 Part (White, Yellow)**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish: None**  
**Drill: None**  
**Misc Info: ss; black; 2 part;**

McLaren Form  
Implanted / Extended Device Record

Implanted     Extended Device Record

Date: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Procedure/Locations: \_\_\_\_\_

Place manufacturer product label in the space below, and/or write in the following information:

Device description:

Name: \_\_\_\_\_

S/N/Lot #: \_\_\_\_\_

Catalog #: \_\_\_\_\_

Manufacturer: \_\_\_\_\_

Model #: \_\_\_\_\_

Quantity: \_\_\_\_\_

Exp. Date: \_\_\_\_\_

<p><b>Tissue Package Integrity</b></p> <p>Supplier Package Intact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Product Package Intact: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Temperature Maintained: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Product Label Legible: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>Reconstitution</b></p> <p>Reconstitution: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Reconstitution by: _____</p> <p>Reconstitution Date/Time: _____</p> <p>Reconstitution instructions available: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Type of Fluid: _____</p> <p>Lot # of Fluid: _____</p> <p>Exp. Date of Fluid: _____</p>
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Implants sterilized in house: Date of sterilization: \_\_\_\_\_

CPD: \_\_\_\_\_ Sterilization Load Number: \_\_\_\_\_

OR: \_\_\_\_\_ Sterilizer Used: \_\_\_\_\_ Cycle Count #: \_\_\_\_\_

In the event of an Explicit, provide the following information:

Reason for removal: \_\_\_\_\_

Final Disposition: \_\_\_\_\_

In the event of a cardless Explicit, provide the following information:

Length of warranty: \_\_\_\_\_

Parameter settings: \_\_\_\_\_

IMPLANTED/EXTENDED  
 DEVICE RECORD  
 M-17459-REV 12/2016



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