

McLaren Print System Order

Order No: 63907 Reprint Previous Order No: 42821
Order Date: 2021-07-28
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: 500
Paragon Dept No: 30014
Dept Name: Surgery and Endoscopy Center Pain Clinic
Company Number: 60

Order Total Price: 563.50

Item Number: 17497
Item Description: Pain Clinic Visit and Discharge
Revision Date: 1/2019
Print: 1 sided black and white
Paper: 3 Part (White, Yellow, Pink)
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info: 2 PAGES - 3 PART

McLaren Flint Pain Clinic Follow-up Form

Your Next Visit is for: Return visit to Can be used by NP Postoperative Procedure (See Below)

Your next Appointment/Procedure date and time is: _____

Please check the box that applies with site and level:

<input type="checkbox"/> Cervical level location	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Sacral	<input type="checkbox"/> Sacral with coccyx
<input type="checkbox"/> Unilateral level location	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Bilateral	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Sacral L
<input type="checkbox"/> Cervical level	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Cervical site	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Lumbar level	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Bilateral		
<input type="checkbox"/> Lumbar site	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Bilateral		
<input type="checkbox"/> Sacral / Coccyx / Hip location	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Bilateral		
<input type="checkbox"/> Sacral / Coccyx / Hip site	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Bilateral		

If needed for a procedure, please hold the following medications (N/A) after getting approval from your Primary Care Physician (Cardiologist)

____ Hold _____ for _____ (N/A) for _____

____ Hold _____ for _____ (N/A) for _____

____ Hold _____ for _____ (N/A) for _____

____ Hold _____ for _____ (N/A) for _____

____ Hold _____ for _____ (N/A) for _____

____ Hold _____ for _____ (N/A) for _____

____ Hold _____ for _____ (N/A) for _____

____ Hold _____ for _____ (N/A) for _____

____ Hold _____ for _____ (N/A) for _____

____ Hold _____ for _____ (N/A) for _____

____ Hold _____ for _____ (N/A) for _____

InterPage 0000


