

McLaren Print System Order

Order No: 55954
 Order Date: 2020-08-06
 User: Patricia Peterson
 Phone: (810) 324-2193

Ship Location: McLaren Flint - P.A.T. (1 central) Attn: Tricia P.
 401 S, Ballenger Hwy.
 Flint, MI 48532

Forms

Quantity: 1000
 Paragon Dept No: 30510
 Dept Name: Pre-Admission Testing
 Company Number: 60

Order Total Price: 0.00

Item Number: 3805
 Item Description: Patient Belonging Inventory
 Revision Date: 1/2014
 Print:
 Paper:
 Size:
 Fold:
 Finish:
 Drill:
 Misc Info:

BLANKET/UNIT
 For Storage

PATIENT BELONGINGS INVENTORY

ARTICLES OF CLOTHING BROUGHT TO HOSPITAL									
Underwear	Shoes	Accessories	Shower Slippers	Slippers	Slippers	Shower Slippers	Shower Slippers	Shower Slippers	Shower Slippers
Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts
Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts
Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts
Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts	Shirts

Other: _____

VALUABLES BROUGHT TO HOSPITAL									
Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches
Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches
Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches
Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches
Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches	Watches

Other: _____

*Indicates items received on 1/1/01

I have read the following and acknowledge:

- McLaren Files will use for billing purposes for any money or property of any kind retained by me or kept in my possession while I am at the hospital.
- Please take all Valuables home when possible.
- After 90 Days McLaren Files will dispose of all unclaimed property left at the Medical Center. Please call Security at (810) 324-2193 to claim any valuables after discharge.

Patient Signature: _____ Date: ____/____/____

Witness: All I am Patient Responsible Party Relationship (to patient): _____

Receiving Unit: _____ Nursing Staff Signature: _____ DQA

Patient has no belongings or belongings were taken with Patient Family or Representative.

PATIENT TRANSFER BELONGING INFORMATION

Checking & Valuation with Patient as Individual Above	From room #:	To room #:	Checking & Valuation with Patient as Individual Above	From room #:	To room #:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Security Signature: _____ Date: ____/____/____

All of my belongings have been returned to me.
 Patient Signature: _____ Date: _____

Spec Info: Please always 5 hole punch top of form.