

**McLaren Print System Order**

Order No: 56668  
 Order Date: 2020-09-08  
 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: 0.00

Item Number: MTR-08  
 Item Description: EMERGENCY DEPART RECORD - PHYSICIAN ORDER SHEET  
 Revision Date: 6/2019  
 Print: 1 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish: None  
 Drill: None  
 Misc Info: SS; BLACK; BOND PAPER

**EMERGENCY DEPARTMENT RECORD-PHYSICIAN ORDER SHEET**

Lab/ Radiology/ Cardio-Pulmonary- See CPCE Orders

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

|  |   |
|--|---|
| Medication Orders<br><input type="checkbox"/> Stroke Protocol Alteplase (TPA)<br><input type="checkbox"/> MI Protocol Tenecteplase (TNP)<br><br><input type="checkbox"/> _____<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____ | N/ _____ ml Bolus<br>then _____ ml/hr<br>2nd N/ _____ ml/hr<br><br><input type="checkbox"/> _____<br><input type="checkbox"/> _____<br><input type="checkbox"/> _____ |
|--|---|

Nursing Signature Initials: \_\_\_\_\_

**Spec Info:**

Disposition:  Discharge  Observe  Critical  Critical  
 Isolated  Observation  Ambulatory (one day surgery)  Discharge  AMA  WBS

Transfer to: \_\_\_\_\_ Accepting Dr: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Exam R: \_\_\_\_\_ Tech/BN Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

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