

**McLaren Print System Order**

Order No: 71848 Reprint Previous Order No: 54291  
 Order Date: 2022-08-23  
 User: Kirsten Grass  
 Phone: 989-269-1566

Ship Location: McLaren Thumb Region  
 1100 S. Van Dyke Rd  
 Bad Axe, MI 48413

**Forms**

Quantity: 500  
 Paragon Dept No: 4540  
 Dept Name: Emergency Department  
 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 48413  
 (989) 269-9521

**EMERGENCY DEPARTMENT RECORD-PHYSICIAN ORDER SHEET**

Lab/ Radiology/ Cardio-Pulmonary- See CPCE Orders	
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/ID) <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  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 _____
Medication Orders <input type="checkbox"/> Stroke Protocol Alteplase (TPA) <input type="checkbox"/> MI Protocol Tenecteplase (TNP)  <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	N/ _____ ml Bolus then _____ ml/hr 2nd N/ _____ ml/hr  <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

Nursing Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Discharge Time: _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> Observation <input type="checkbox"/> Ambulatory (one day surgery) <input type="checkbox"/> Discharge <input type="checkbox"/> AMA <input type="checkbox"/> WBS Transfer to: _____ Accepting Dr: _____ Physician Signature: _____ Date: _____ Time: _____ Signature: _____ Room # _____ Tech/BN Initials: _____ Date: _____ Time: _____
--

363716.01