

McLaren Print System Order

Order No: 77130
Order Date: 2023-05-05
User: Pamela Sweeney
Phone: 989-269-9521

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

Forms
Quantity: 100
Paragon Dept No: 30670
Dept Name: OB
Company Number: 530

Order Total Price: 0.00

Item Number: Pre-Anesthesia Assessment
Item Description: Pre-Anesthesia Assessment
Revision Date: 08/2020
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Poster:
Misc Info: SS; BLACK; BOND PAPER

McLaren
THUMB REGION
Pre-Anesthesia Assessment

Date of Surgery: _____ Tolerated Date: _____
Age: _____ Sex: _____
Height: _____ Weight: _____
Blood Pressure: _____

Medical History		Surgical History	
Y	N	Y	N
<input type="checkbox"/> Hypertension	<input type="checkbox"/>	<input type="checkbox"/> Colon	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Gallbladder	<input type="checkbox"/>
<input type="checkbox"/> Heart Disease	<input type="checkbox"/>	<input type="checkbox"/> Stomach	<input type="checkbox"/>
<input type="checkbox"/> Lung Disease	<input type="checkbox"/>	<input type="checkbox"/> Kidney	<input type="checkbox"/>
<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Pancreas	<input type="checkbox"/>
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<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/> Gynecology	<input type="checkbox"/>
<input type="checkbox"/> Anesthesia	<input type="checkbox"/>	<input type="checkbox"/> Urology	<input type="checkbox"/>
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<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/>
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<input type="checkbox"/> Past Surgical History	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
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<input type="checkbox"/> Past Surgical History	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
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<input type="checkbox"/> Medications	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Current Medications	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Past Medical History	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Past Surgical History	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
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<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Anesthesia	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Medications	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Current Medications	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Past Medical History	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Past Surgical History	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Anesthesia	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
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<input type="checkbox"/> Past Surgical History	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Blood Clots	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>