

McLaren Print System Order

Order No: 77324
 Order Date: 2023-05-16
 User: Tiffany Glover
 Phone: 989-894-6926

Ship Location: Attn Tiffany
 1900 Columbus Ave South Tower 4th Floor
 Bay City , Michigan 48708

Forms

Quantity: 100
 Paragon Dept No: 69430
 Dept Name: Bay Heart and Vascular
 Company Number: 210

Order Total Price: 11.80

Item Number: BRHV-2002
 Item Description: Procedure Pakekt/Order
 Revision Date: 04/2021
 Print: 1 sided black and white
 Paper: 2 Part (White, Yellow)
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Poster:
 Misc Info:

McLaren
BAY HEART & VASCULAR

1900 COLUMBUS AVE • BAY CITY, MI 48708
 (989) 894-3278 • FAX (989) 891-0908

2110 S. M-74, STE. B • WEST BRANCH, MI 48661
 (989) 516-0100 • FAX (989) 343-0485

PROCEDURE PACKET/ORDER

PATIENT NAME _____ DOB _____ DR. _____
 PHONE _____ DIAGNOSIS _____ DATE _____

INSURANCE _____ 2ND OPTION _____
 PROCEDURE: EP STUDY EP STUDY WITH ABLATION CARTO NOTIFIED: YES NO
 TIE CV TLT TREADMILL STRESS TEST
 PPM ICD BVACO BV/PPM LOOP RECORDER GENERATOR CHANGE

DEVICE VENDOR: S.M. MEDTRONIC BOSTON SCIENTIFIC BIOTRONIK NOTIFIED: YES NO
 HOSPITAL _____ DATE _____ TIME _____ SCHEDULED WITH _____
 LABS TO BE COMPLETED: CHEM 7, MG, CBC, PT/INR, PTL, BETA/NGF FOR WOMEN LESS THAN 45
 ORDERED BY _____ FAMILY DR. _____ PHONE _____ NOTIFIED: _____
 Instructions: _____

EMPLANT CONSENT FORM _____ SIGNED: _____
 ICD/IV REGISTRY FORM _____ SIGNED: _____ FAXED: _____
 ALLERGIES: _____
 DIABETES _____ DIET CONTROL _____ ORAL _____ INSULIN _____
 ANTICOAGULATION (ICOU/ADONVASA/PRADAXA) _____
 ECHO: _____ DATE _____ HOSPITAL: _____
 PREVIOUS CATH _____ DATE _____ HOSPITAL: _____

DRUG THERAPY - PATIENT NOTIFIED TO HOLD ALL ANTIARRHYTHMIC MEDICATIONS (INCLUDING CALCIUM CHANNEL BLOCKERS AND BETA BLOCKERS) PRIOR TO EP STUDY. CONSULT DR. MAHMOUD FOR HOW LONG

ANTIARRHYTHMICS: _____
BETA BLOCKERS: _____
CA CHANNEL BLOCKERS: _____

(INITIALS) SCHEDULED BY: _____ UPN/RN: _____ PACKET: _____

PATIENT RECORDS ATTACHED:

<input type="checkbox"/> CURRENT MEDICATION LIST _____	<input type="checkbox"/> RECENT CONDUIT _____	REPORT DATE _____
<input type="checkbox"/> RECENT (KG) OF ABRIVITHRPA _____	<input type="checkbox"/> HOLTER _____	REPORT DATE _____
<input type="checkbox"/> CHEST X-RAY (UNILATERAL) _____	<input type="checkbox"/> H&P _____	REPORT DATE _____
<input type="checkbox"/> ECHO _____	<input type="checkbox"/> RECENT LABS _____	REPORT DATE _____

ORDERING PHYSICIAN SIGNATURE _____ DATE _____ TIME _____

100B PROCEDURE ORDER PACKET

888 986 4371 ORIGINAL MEDICAL RECORD TELEPHONIC COPY HOSPITAL

Spec Info: