

McLaren Print System Order

Order No: 77581  
Order Date: 2023-05-29  
User: Kirsten Grass  
Phone: 9892691566

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

Forms

Quantity: 1000  
Paragon Dept No: 4540  
Dept Name: Emergency Department  
Company Number: 530

Order Total Price: 224.00

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  
Poster:  
Misc Info: SS; 2 PART

EMERGENCY DEPARTMENT RECORD-PHYSICIAN ORDER SHEET

<b>Lab/ Radiology/ Cardio-Pulmonary- See CPCE Orders</b> <input type="checkbox"/> Nasal Ointment <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Orthostatic Vitals <input type="checkbox"/> Foley Cath-Inserting <input type="checkbox"/> Straight Cath <input type="checkbox"/> NG Tube <input type="checkbox"/> Intermittent <input type="checkbox"/> Cont. <input type="checkbox"/> Wound Closure <input type="checkbox"/> Dressing/MS <input type="checkbox"/> Betadine <input type="checkbox"/> NS <input type="checkbox"/> Suture Set up <input type="checkbox"/> Staples <input type="checkbox"/> Dressing <input type="checkbox"/> OBL, Ase Drl <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 _____Ankle  <b>Consultations -</b> <input type="checkbox"/> Tele-Stroke 03014 / 6012874 <input type="checkbox"/> Tele-Psychiatry 03014 / 6012874 <input type="checkbox"/> Tele-Cardiology 03014 / 6012874 <input type="checkbox"/> Other _____
<b>Medication Orders</b> <input type="checkbox"/> Stroke Protocol Alteplase (TPA) <input type="checkbox"/> tPA Protocol Tenecteplase (TNR)  <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	NR _____ ml Bolus then _____ ml/hr  2nd NR _____ ml/hr  <input type="checkbox"/> _____ <input type="checkbox"/> _____

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

**Spec Info:**

Decision Time: _____ <input type="checkbox"/> System <input type="checkbox"/> Observation <input type="checkbox"/> Ambulatory (one day surgery) <input type="checkbox"/> Discharge <input type="checkbox"/> AMA <input type="checkbox"/> CS, WBS
Transfer to: _____ Accepting Dr: _____
Physician Signature: _____ Date: _____ Time: _____
Signature: _____ Room # _____ Tele/ENR Initials: _____ Date: _____ Time: _____

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