

McLaren Print System Order

Order No: 79286
Order Date: 2023-09-11
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

1100 S. Van Dyke
Bad Axe, Michigan 48413
(989) 269-9521

EMERGENCY DEPARTMENT RECORD-PHYSICIAN ORDER SHEET

Lab: Radiology Cardio-Pulmonary- See CPCE Orders

<p>Nursing Orders</p> <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 Cleanse <input type="checkbox"/> Debride/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 <p>Consultations -</p> <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 _____
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<p>Medication Orders</p> <input type="checkbox"/> Stroke Protocol Alteplase (TPA) <input type="checkbox"/> tPA Protocol Tenecteplase (TNK) <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<p>NR _____mi Bolus then _____mg/hr 2nd NR _____mg/hr <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ </p>
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Nursing Signature/Initials: _____

Spec Info:

<p>Residence Type: _____ <input type="checkbox"/> Disposition: <input type="checkbox"/> Discharge <input type="checkbox"/> AMA <input type="checkbox"/> CS, WBS <input type="checkbox"/> Observation <input type="checkbox"/> Ambulatory (one day surgery) <input type="checkbox"/> Discharge <input type="checkbox"/> AMA <input type="checkbox"/> CS, WBS</p> <p>Transfer to: _____ Accepting Dr: _____</p> <p>Physician Signature: _____ Date: _____ Time: _____ Signature: _____ Room # _____ Tach/BN Initials: _____ Date: _____ Time: _____</p>

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