

McLaren Print System Order

Order No: 85697
 Order Date: 2024-05-22
 Order Request Date:
 User: Corinna Kranz
 Phone: 989-269-2882

Ship Location: McLaren Thumb - Attn: Corinna K
 1100 S Van Dyke Road
 Bad Axe, MI 48413

Brochures
 Quantity: 100
 Paragon Dept No: 17805
 Dept Name: Administration
 Company Number:

Order Total Price: 30.95

Item Number: MHCC-17548
 Item Description: FOOT SCREENING Form
 Revision Date: 05/2024
 Print: 1 sided black and white
 Paper: 3 Part (White, Yellow, Pink)
 Size: 8.5 x 14
 Fold:
 Finish: None
 Drill: None
 Poster:
 Misc Info: 8.5x14 Black 3-Part

**McLAREN
 FOOT SCREENING
 CLINICIAN/WORK ASSESSMENT FORM**

Name: _____ Sex: Male Female Race/Ethnicity: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Email: _____ Age: _____ Height: _____ Weight: _____
 Name and Address of Your Primary Physician: _____
 Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

Do you want Results to Send Your Screening Results to Your Physician? Yes No
 Would you like to receive future health screening program announcements? Yes No Already receive

Have you participated in this screening? _____

Medical History Please circle either "yes" or "no" for each.

1. Diabetes	Yes No	3. History of Stroke	Yes No	10. HTN	Yes No
2. Blood	Yes No	4. History of Diabetes	Yes No	11. Heart/AI	Yes No
5. Current	Yes No	7. Autoimmune Disease	Yes No	12. Hypertension/Stroke	Yes No
6. Rheumatoid	Yes No	8. Neurology	Yes No	13. Other	Yes No

Are you in chemotherapy treatment? Yes No If yes, how much per week? _____ Current Medications: _____

Release Form
 I understand that I am voluntarily agreeing to participate in the McLaren Foot Assessment Screening. This screening is being provided to assist me in identifying potential foot problems that may contribute to poor health. I understand this screening includes glucose level evaluation, an assessment of my pulse and blood pressure and foot assessment. I also understand this screening includes education and information to diagnose or treat any specific illness or disease. I also understand it is my sole responsibility to follow-up assessment with my physician. I agree to voluntarily release McLaren, their employees, agents, volunteers, and other persons acting or not acting on their behalf, from any and all claims or causes of action which are in any way connected to my participation in this screening. I have read and understand the above information.

Participant Signature: _____ Date: _____

Assessment
 Presence of Foot Pathology _____ Recommended/Healthy Date: Yes No

Blood Pressure Results & Recommendations
 Blood Pressure: _____/_____/_____ (left arm) _____/_____/_____ (right arm)
 Normal (Systolic less than 120 / Diastolic less than 80) Continue routine blood pressure checks.
 Elevated (Systolic 120-139 / Diastolic less than 80) Follow-up with physician.

Foot Pulse Assessment
 Pulse Rate: _____ Regular Irregular

Microcirculation Assessment
 Normal or Satisfactory Abnormal

Foot Assessment
 Ankle: Yes No Temperature: Cold / Hot / Normal
 Calf: Yes No Throat: Yes No
 Dorsal: Yes No Moist: Yes No
 Heel: Yes No
 Medial: Yes No
 Radial: Yes No
 Sensing: Yes No

Screening Results
 Screening: Passing Non-Passing
 Normal (50-99 mg/dl) Pre-Diabetes (100-125 mg/dl) Diabetes (126 mg/dl or higher)

Action Plan
 See your doctor to check: Blood Pressure Foot Pulse Sensing
 Diabetes Other _____
 Within 1 month Within 3 months Within 6 months Other _____

Other Considerations: Self-Screening Health Coaching Other _____ Screening/Results Frequency: _____

CLINICIAN/WORK ASSESSMENT FORM

Spec Info: