

McLaren Print System Order

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 Phone: 989-672-5795

Ship Location: McLaren Caro Region
 401 N. Hooper Street
 Caro, MI 48723

Forms

Quantity: 100
 Paragon Dept No: 8837
 Dept Name: Radiology
 Company Number: 510

Order Total Price: 5.48

Item Number: CR-028
 Item Description: PVD Screening Form
 Revision Date: 4/2019
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: Padded (50 Sheets Per Pad)
 Drill: None
 Misc Info: ds; black & white

McLaren Caro Region
PERIPHERAL VASCULAR DISEASE (PVD) SCREENING FORM AND RELEASE OF RESULTS

Name _____ Phone _____ Email _____
 Address _____ City _____ Zip _____
 Male Female Date of Birth ____/____/____ Age ____ Height ____ Weight ____ Race/Ethnicity _____

NAME AND ADDRESS OF YOUR PRIMARY CARE PHYSICIAN:
 Name _____ Phone _____
 Address _____ City _____ Zip _____

DO YOU WANT McLAREN-CARO REGION TO SEND YOUR SCREENING RESULTS TO YOUR PHYSICIAN? Yes No
 Would you like to receive future health screening & program announcements? Yes No Already receive
 How did you learn about this screening? _____

Welcome to the screening for Peripheral Vascular Disease (PVD). We are glad that you care about your health and came in today. This program will give you information on PVD and screen you for the problem. The screening process is very simple. The results, along with your answers to the questionnaire, will allow the physician or health care professionals to determine if you are at high, moderate, low or no apparent risk for PVD. If the screening indicates you have risk factors for PVD, you will be advised to see your physician for further consultation.

RELEASE FORM:
 I hereby release the screening physicians, all other health care volunteers and McLaren Caro Region from all responsibility in connection with this screening exam. I understand that I will be only screened for risk factors or symptoms of PVD and that this screening does not constitute a complete medical exam or diagnosis. I have read this form and understand this information.

Participant Signature _____ Date _____

MEDICAL HISTORY: Please circle either "yes" or "no" for each.

Do you experience any of the following symptoms in your legs?

1. Aching/pain in your legs?	Yes	No	7. Restless legs?	Yes	No
2. Itching/numb?	Yes	No	8. Tingling?	Yes	No
3. Tiredness/fatigue?	Yes	No	9. Skin ulcers?	Yes	No
4. Itching/numb?	Yes	No	10. Does the pain get worse with activity?	Yes	No
5. Swollen ankles?	Yes	No	11. Does the pain get better with elevation of the legs?	Yes	No
6. Leg cramps?	Yes	No	12. Do you wear compression stockings?	Yes	No

Have you ever been seen for problems in your legs? Yes No
 If yes, please list symptoms: _____

Do you have cardiovascular (heart) problems, such as high blood pressure, heart attack, or stroke? Yes No
 Do you have diabetes? Yes No
 Do you smoke? Yes No
 Have you smoked more than 100 cigarettes in your lifetime? Yes No
 Have you had a recent stroke or stroke-like symptoms? Yes No
 Do you have a family history of Abdominal Aortic Aneurysm? Yes No

ASSESSMENTS:

Blood Pressure: Results & Recommendations

Left arm: _____	Right arm: _____
_____ (Systolic) _____ (Diastolic)	_____ (Systolic) _____ (Diastolic)
<input type="checkbox"/> Normal (Systolic: less than 120/Diastolic: less than 80)	Continuous routine blood pressure checks
<input type="checkbox"/> Elevated (Systolic: 120-129/Diastolic: less than 80)	Follow-up with physician at next visit
<input type="checkbox"/> Hypertension Stage 1 (Systolic: 130-139/Diastolic: 80-89)	Follow-up with physician within 1 week
<input type="checkbox"/> Hypertension Stage 2 (Systolic: 140 or higher/Diastolic: 90 or higher)	Follow-up with physician immediately
<input type="checkbox"/> Hypertension Crisis (Systolic: 160 or higher/Diastolic: 100 or higher)	Emergency care needed

PVD SCREENING FORM AND RELEASE OF RESULTS
 CR-028-001

Spec Info: