

McLaren Print System Order

Order No: 46663 Reprint Previous Order No: 5557  
Order Date: 2019-06-28  
User: McCorry Debbie  
Phone: 77357

Ship Location: McLaren Lapeer Region Community Medical Center Debbie  
1254 Main  
Lapeer, MI 48446

Forms

Quantity: 1000  
Paragon Dept No: 65000  
Dept Name: McLaren Lapeer Region Community Medical Center  
Company Number: 810

Order Total Price: 176.00

Item Number: MM-17283  
Item Description: Pre-Operative Clearance Consultation  
Revision Date: 4/2008  
Print: 2 sided full color  
Paper: 28# Color Copy Text  
Size: 8.5 x 11  
Fold:  
Finish:  
Drill: None  
Misc Info:

McLaren Ambulatory Care Center  
PRE-OPERATIVE CLEARANCE CONSULTATION

\*requires completion of all highlighted areas

Requested by \_\_\_\_\_ M.D. or \_\_\_\_\_ Date \_\_\_\_\_  
O.C.

Reason \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies \_\_\_\_\_  
Current Medications \_\_\_\_\_

Past Medical History (check if present) or NONE

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes Mellitus
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Type I
<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> GERD	<input type="checkbox"/> Type II
<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> CVA	<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Murmur	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other _____
<input type="checkbox"/> Pectus/MI/ICD	<input type="checkbox"/> Transient Ischemic Attack	<input type="checkbox"/> Chronic Kidney Disease
<input type="checkbox"/> COPD	<input type="checkbox"/> Seizures	<input type="checkbox"/> Bleeding Disorders

Past Surgical History \_\_\_\_\_

Social History

<input type="checkbox"/> Occupation _____	<input type="checkbox"/> Drugs _____
<input type="checkbox"/> Smoking _____	<input type="checkbox"/> Abuse (Psychosocial) _____
<input type="checkbox"/> Alcohol _____	

Family History

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Malignant Hypertension
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	

Review of Systems (check if present) or NONE

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Altered Bowel Habits
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Constipation	<input type="checkbox"/> Altered Bladder Habits
<input type="checkbox"/> Cough	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dyspepsia/Dysphagia
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/> Anorexia/Weight Loss
<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Fatigue/Weakness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Light-Sensitivity	<input type="checkbox"/> Weakness in Extremities

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