

**McLaren Print System Order**

Order No: 49542 Reprint Previous Order No: 8641  
 Order Date: 2019-10-17  
 User: Lisa Ardanowski  
 Phone: 810-768-2073

Ship Location: McLaren Surgery and Endoscopy Center Attn: Lisa Ardanowski  
 501 S. Ballenger Hwy  
 Flint, MI 48532

**Forms**

Quantity: 1000  
 Paragon Dept No: 30014  
 Dept Name: Surgery and Endoscopy Center Pain Clinic  
 Company Number: 60

Order Total Price: 182.00

Item Number: 17025-6  
 Item Description: Endoscopy Report  
 Revision Date: 1/2016  
 Print: 1 sided black and white  
 Paper: 3 Part (White, Yellow, Pink)  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: None  
 Misc Info:

MCLAREN SURG  
 PAIN SERVICES  
**ENDOSCOPY REPORT**

DIAGNOSTIC  
 ELECTIVE  
 THERAPEUTIC  
 EMERGENCY

All BOLD Elements REQUIRED by CMS & Joint Commission. Please Fully Complete.

GASTROENTEROLOGIST \_\_\_\_\_ DATE \_\_\_\_\_

HISTORY  HEMATEMESIS  MELENA  HEMIA  MASS LESION  ULCER  UNEXPLAINED PAIN  
 HEMPTOCHEZIA  DIARRHEA  FAMILY HISTORY OF CA  INFLAMMATORY BOWEL DISEASE  
 OTHER \_\_\_\_\_

(LT) _____	(RT) _____	(RT) _____	(RT) _____	
ESOPHAGUS: <input type="checkbox"/> NORMAL <input type="checkbox"/> ESOPHAGITIS <input type="checkbox"/> HIAL HERNIA <input type="checkbox"/> REFLUX <input type="checkbox"/> SCHWARTZ'S RING <input type="checkbox"/> CARCINOMA				
<input type="checkbox"/> VARICES				
<input type="checkbox"/> OTHER _____				
STOMACH: <input type="checkbox"/> NORMAL <input type="checkbox"/> GASTRITIS <input type="checkbox"/> ULCER <input type="checkbox"/> POLYPS <input type="checkbox"/> LYMPHOMA <input type="checkbox"/> CARCINOMA <input type="checkbox"/> VARICES				
<input type="checkbox"/> Stricture <input type="checkbox"/> Strang <input type="checkbox"/> HYPERGASTRY				
<input type="checkbox"/> Erosive <input type="checkbox"/> Malignant <input type="checkbox"/> Superficial				
<input type="checkbox"/> OTHER _____				
DUODENUM: <input type="checkbox"/> NORMAL <input type="checkbox"/> DUODENITIS <input type="checkbox"/> ULCER <input type="checkbox"/> POLYPS				
<input type="checkbox"/> OTHER _____				
<input type="checkbox"/> LOCATION _____				
RECTOSIGMOID: _____	NORMAL	INFLAMMATION	POLYP	CARCINOMA
DESCENDING: _____				
TRANSVERSE: _____				
ASCENDING: _____				
CECUM: _____				
SIGMUM: _____				

**PROCEDURE**

PRE-OPERATIVE DIAGNOSIS: \_\_\_\_\_

ENDOSCOPIC DIAGNOSIS/GROSS FINDINGS: \_\_\_\_\_

No bleed seen unless noted \_\_\_\_\_

No specimen removed unless noted \_\_\_\_\_

Complications: \_\_\_\_\_

NO ASSISTANT(S) UNLESS NOTED: \_\_\_\_\_

SIGNATURE OF PHYSICIAN: \_\_\_\_\_ W.D.S.O. SAFE/TIME \_\_\_\_\_

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