

**McLaren Print System Order**

**Order No: 56670**  
**Order Date: 2020-09-08**  
**User: Tim Zurek**  
**Phone: 9892699521**

**Ship Location: McLaren Thumb Region Emergency Room Attn: Tim**  
**1100 S. Van Dyke Rd.**  
**Bad Axe, MI 48731**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 060**  
**Dept Name: Emergency Room**  
**Company Number: 530**

**Order Total Price: 117.00**

**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**  
**Misc Info: SS; 2 PART**

**McLaren** 1100 S. Van Dyke  
Bad Axe, Michigan 48731  
(989) 269-9521

**EMERGENCY DEPARTMENT RECORD-PHYSICIAN ORDER SHEET**

Lab/ Radiology/ Cardio-Pulmonary- See CPCE Orders

<b>Nursing Orders</b> <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Orthostatic Vitals <input type="checkbox"/> Foley Cath-Indwelling <input type="checkbox"/> Straight Cath <input type="checkbox"/> NG Tube <input type="checkbox"/> Interm <input type="checkbox"/> Cont <input type="checkbox"/> Wound Care <input type="checkbox"/> Irrigation <input type="checkbox"/> NS <input type="checkbox"/> Suture Set up <input type="checkbox"/> Staples <input type="checkbox"/> Dressing <input type="checkbox"/> OBL, Ate Oint <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 _____AIRB  <b>Consultations -</b> <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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**Medication Orders**  
 Stroke Protocol Alteplase (TPA)  
 MI Protocol Tenecteplase (TNP)  
  
N<sup>o</sup> \_\_\_\_\_ ml Bolus  
then \_\_\_\_\_ ml/hr  
2<sup>nd</sup> hr \_\_\_\_\_ ml/hr

Nursing Signature Initials: \_\_\_\_\_

**Spec Info:**  
 Discharge  Observation  Discharge  Discharge  Discharge  Discharge  Discharge  
 Discharge  Discharge  Discharge  Discharge  Discharge  Discharge

Transfer to: \_\_\_\_\_ Accepting Dr: \_\_\_\_\_  
Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Signature: \_\_\_\_\_ Room # \_\_\_\_\_ Tech/BN Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

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