



Physician Orders

Care Set: Carotid Perc Angio w/Stent Placement Post Proc Orders

[X or R] = will be ordered unless marked out.

T= Today; N = Now (date and time ordered)

Height: _____ cm Weight: _____ kg

Allergies:		<input type="checkbox"/> No known allergies
<input type="checkbox"/> Medication allergy(s): _____		
<input type="checkbox"/> Latex allergy <input type="checkbox"/> Other: _____		
Admission/Transfer/Discharge		
<input type="checkbox"/>	Return Patient to Room	T;N
<input type="checkbox"/>	Transfer Patient	T;N
<input type="checkbox"/>	Notify Physician-Once	T;N, Notify of room number upon admission
Primary Diagnosis: _____		
Secondary Diagnosis: _____		
Vital Signs		
<input type="checkbox"/>	Vital Signs w/Neuro Checks	T;N, Monitor and Record T,P,R,BP, w/neuro checks q15min for 1 hr, then q30min for 2hr, then q1h until stable, then routine
Activity		
<input type="checkbox"/>	Bedrest	T;N, for 6 hours post sheath removal then up ad lib.
Food/Nutrition		
<input type="checkbox"/>	Force Fluids	T;N, force PO fluids
<input type="checkbox"/>	Full Liquid Diet	Start at: T;N
<input type="checkbox"/>	American Heart Association Diet (AHA Diet)	Start at: T;N
<input type="checkbox"/>	1800 Calorie ADA Diet	
Patient Care		
<input checked="" type="checkbox"/>	Nursing Communication	T;N, No heparin through sheath
NOTE: If patient has sheath order the following:		
<input type="checkbox"/>	Sheath Remove	T;N, Special Instructions: when ACT <180 sec
<input type="checkbox"/>	Sheath Remove	T;N, Special Instructions: when ACT <210 sec
<input type="checkbox"/>	Sheath Remove	T;N Routine, Special Instructions: pull sheath 2 hours after Angiomax discontinued.
<input type="checkbox"/>	Vascular Compression Apply	T;N, Method: Femostop
<input type="checkbox"/>	Vascular Compression Apply	T;N, Method: C-Clamp
<input type="checkbox"/>	Groin Check	T;N,q15min,For 1 hr,then q30min for 2hr, then q1h until stable, then routine
<input type="checkbox"/>	Groin Check	T;N,Routine,q15min,For 1 hr,after sheath removal, then q30min for 2hr, then PRN
Continuous Infusions		
<input type="checkbox"/>	Sodium Chloride 0.9%	500 mL, IV, STAT, (1 dose), 1,000 mL/hr, Bolus
<input type="checkbox"/>	Sodium Chloride 0.9%	1,000 mL, IV, Routine, 75 mL/hr
<input checked="" type="checkbox"/>	Sodium Chloride 0.45%	1,000 mL, IV, Routine, 75 mL/hr
<input type="checkbox"/>	Dextrose 5% with 0.45% NaCl	1,000 mL, IV, Routine, 75 mL/hr
<input type="checkbox"/>	Dextrose 5% in Water	1,000 mL, IV, Routine, 75 mL/hr
Medications		
<input type="checkbox"/>	clopidogrel	300 mg,Tab,PO,once,Routine,T;N
<input type="checkbox"/>	clopidogrel	75 mg,Tab,PO,qam,Routine,T;N
<input type="checkbox"/>	aspirin	81 mg,EC Tablet,PO,QDay,Routine,T;N
<input type="checkbox"/>	aspirin	325 mg,EC Tablet,PO,QDay,Routine,T;N
Consults/Notifications		

Date **Time** **Physician's Signature** **MD Number**

