

attach patient label here



Physician Orders ADULT
Order Set: RAD Neuro Stent-Aneurysm Embolization
Post Proc Orders

[R] = will be ordered

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: _____		
Vital Signs		
<input type="checkbox"/>	Vital Signs w/Neuro Checks	T;N, Monitor and Record T,P,R,BP, q15m, For 1 hr then q1h, For 4 hrs then per Neuro ICU protocol.
Activity		
<input type="checkbox"/>	Bedrest	T;N, For 6 hr, post Neuroform Stent/Aneurysm Embolization
<input type="checkbox"/>	Bedrest	T;N, For 2 hr, post Neuroform Stent/Aneurysm Embolization
<input type="checkbox"/>	Bedrest	T;N, For 4 hr, post Neuroform Stent/Aneurysm Embolization
<input type="checkbox"/>	Bedrest	T;N, For 8 hr, post Neuroform Stent/Aneurysm Embolization
<input type="checkbox"/>	Bedrest	T;N, Strict, post Neuroform Stent/Aneurysm Embolization
Food/Nutrition		
<input type="checkbox"/>	Force Fluids	T;N, For 24 hr, post Neuroform Stent/Aneurysm Embolization
Patient Care		
<input type="checkbox"/>	Advance Diet As Tolerated	T;N, following Neuroform Stent/Aneurysm Embolization
<input type="checkbox"/>	Keep Affected Leg Straight	T;N, post Neuroform Stent/Aneurysm Embolization
<input type="checkbox"/>	Groin Check (Check Groin)	T;N, q30m, For 1.5 hrs then q1h, For 4 hrs then when checking Vital Signs, post Neuroform Stent/Aneurysm Embolization
Continuous Infusions		
<input type="checkbox"/>	Sodium Chloride 0.45%	500 mL, Femoral Cath,Routine,T;N,10 mL/hr, Comment: to keep sheath open, through femoral sheath
NOTE: Peripheral/Central IV Choices:		
<input type="checkbox"/>	Sodium Chloride 0.45%	500 mL, IV, Routine, T;N, 50 mL/hr
<input type="checkbox"/>	Sodium Chloride 0.9%	500 mL, IV, Routine, T;N, 50 mL/hr
Medications		
<input type="checkbox"/>	ketorolac	15 mg, Injection, IV Push, once, Routine, T;N
<input type="checkbox"/>	aspirin	325 mg, EC Tablet, PO, QDay, Routine, T;N
<input type="checkbox"/>	clopidogrel	75 mg, Tab, PO, QDay, Routine, T;N
<input type="checkbox"/>	ibuprofen	400 mg, Tab, PO, q8h, PRN Pain, Mild (1-3), Routine, T;N
<input type="checkbox"/>	acetaminophen-HYDROcodone 325-7.5 mg oral tablet	1 tab, Tab, PO, q4h, PRN Pain, Moderate (4-7), Routine, T;N
Consults/Notifications		
<input type="checkbox"/>	Notify Physician-Continuing	T;N, Notify: Radiology Special Procedure Dept, if bleeding, swelling, shortness of breath, chest pain

Date

Time

Physician's Signature

MD Number

RAD Neuroform Stent-Aneurysm
 Embolization Post Proc - 21618-QM0309-
 Ver5 092410

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