LeBonheur Children's Medical Center

attach patient label

PHYSICIAN ORDERS

Care Set: Pediatric Cerebral Arteriogram & Intracarotid Amytal Test (WADA Test)

Date: _____ Time: _____ Weight: _____ kg Height: _____ cm BSA _____

Admission	
Admit to Dr. _____	[ ] Floor
Status: [ ] Inpatient [ ] Observation	[ ] Neuro Step-down Unit
[ ] Notify physician of room number on arrival to unit	
Primary Diagnosis: _____	
Secondary Diagnosis:	
Allergies: [ ] No known allergies	[ ] Latex allergy [ ] Other:
[ ] Medication allergy(s):_____	
Vital Signs	
[ ] Vital Signs and neuro checks q 1 hr x 2 hrs, then q 2 hrs x 8 hrs, then q 4 hrs x 48 hrs, then q 8 hrs	
[ ] Q 2 hrs	
[ ] Q 4hrs	
[ ] Routine	
Activity	
[ ] Bedrest	
[ ] Out of bed _____ times a day	
[ ] Assist	
[ ] As tolerated	
Food/Nutrition	
[ ] NPO except am seizure meds with a sip of water	
[ ]	
Patient Care	
[ ] Cerebral Arteriogram and Intracarotid Amytal test (WADA Test) scheduled for _____	
[ ] Notify Neuropsychologist Dr. _____ of patient's arrival to the floor	
[ ] Notify Attending M.D. for questions or problems.	
[ ] Record I & O	
[ ] Continuous Pulse OX	
[ ] CP Monitor	
[ ] Elevate Head of Bed 30 degrees or _____	
[ ]	
Medications (this section can be subdivided as necessary)	
[ ] D5 1/4 NS IV at _____ ml/hr	
[ ] D5 1/4 NS IV with 20 mEq KCL/1000ml at _____ ml/hr	
[ ] Sodium Amobarbital 250mg IV - 2 vials, for WADA Test to be delivered to Cardiac Cath Lab and administered by M.D. in Cath Lab.	
[ ]	
[ ]	
[ ]	
[ ]	
[ ]	
Diagnostic Tests	
[ ] **STAT LABS:**	
[ ] PT/PTT	
[ ] INR	
[ ] BMP	
[ ] CBC	
[ ] PLTS	
[ ] B-HCG	
[ ] Anticonvulsant Levels:_____	
_____	
_____	
Consults	
[ ]	
[ ]	
[ ]	

Physician's/Nurse Practitioner's Signature **Name Printed** **Physician Number** **Beeper Number**