UNM HOSPITALS

Date/Time/Initials are required for each order as it is written & taken off

Allergies:_____ Service_____ Weight _____(Kg)

INTERVENTIONAL RADIOLOGY ADMISSION ORDERS

Date Time	MD CNP Initial		Date Time	RN Initials
		Name: _____ **MR#:**_____		
		Date:_____ **Time:** _____		
		Admit		
		Under Service of Dr. _____**, Interventional Radiology**		
		Contact Numbers: Daytime – 272-1818 or 272-2097 **After hours Radiology Resident or General Call** _____ **Radiology, Attending Physician Beeper:** _____ **Cell Phone** _____		
		Diagnosis: _____		
		Condition: Stable _____ **Guarded** _____ **Critical** _____ **or** _____ **Other** _____		
		Allergies: _____		
		Activity:_____		
		DIET & NPO Orders for adults and children . 6 months old: **Give patient's regular medications with water and hold insulin if patient receives it with breakfast.** NPO starting _____now, or starting at _____ _____Advance as Tolerated _____Regular Diet _____Diabetic _____1,500 calorie _____ 1,800 calorie _____2,000 calorie _____Renal _____with no fluid restrictions _____ restrict fluid to _____1 _____ 1.5 _____2 _____/day ☐ If patient has not been NPO (of solid foods) for > 6 hours: Reglan (Metocloprimide) 10 mg PO 1 hr prior **NPO orders for children < 6 months old:** ☐ No solid, semi-solid foods or unclear fluids 4 hours before exam ☐ No clear liquids 2 hours before exam		
		Vital Signs: ☐ Routine ☐ Q _____ ☐ Special Instructions _____		
		Temperature: ☐ q 2 hr ☐ q 4 hr ☐ Other_____		
		IV Fluids: ☐ None ☐ Other _____ ☐ NS @ ☐ 60 cc/hr ☐ 125 cc/hr ☐ or _____cc/hr then _____		
		Special Nursing Instructions (ie catheter, drain care) _____		
		Call Physician for: _____ _____**Increasing hematoma, decreasing pulse or temperature at or distal to arterial puncture.**		

Labs:

		☐ CBC ☐ PT/PTT ☐ Chem 7 ☐ Other		
		Medications/Treatments		
		For Moderate pain: ☐ Tylenol ☐ 325mg. ☐ 500 mg. PO q 4 hrs, PRN pain or fever maximum of 4000 mg/24 hrs ☐ Ibuprofin _____ 600 mg PO q 6 hrs or _____ 800 mg PO q 8 hours PO PRN pain or fever ☐ Celebrex 200 mg. PO prn pain BID ☐ Tylenol III _____ 1 or _____2 PO q 4 hrs prn moderate pain ☐ Percocet (Oxycodone 5 mg/Acetominophen 325 mg) _____ 1 or _____2 PO q 4 hrs prn moderate pain ☐ Vicodin or Lortab (Hydrocodone 5 mg/Acetominophen 500 mg) _____ 1 or _____2 PO q 6 hrs prn pain		

Date	Time	MD/CNP Name-Please Print	Provider #	Signature	Initial
Date	Time	RN Name - Please Print		Signature	Initial
Date	Time	Clerk Name-Please Pr		Signature	Initial

Patient Identification Label

For Severe pain:
☐ Demerol _____25 mg IM, _____50 mg IM q 4-6 hrs prn
And Vistaril _____25 mg IM, _____50 mg IM q 4-6 hrs prn
☐ Demerol _____25 mg, _____50 mg IM q 4-6 hrs prn
☐ Toradol _____15 mg, _____30 mg IM or IV q 6 hrs, for no longer than 5 days
☐ Dilaudid _____2 mg or _____ 4 mg PO q 6 hrs PRN
☐ Morphine _____2 mg or _____4 mg SQ or IV q 2 hrs PRN
☐ IV PCA pump -
Morphine Sulfate - Basal rate 1 mg/hr, 0.5 mg demand on 20 minute lock-out

For Anxiety:
☐ Lorazepam (Ativan) PO or SL _____0.5 mg, ____1 mg, _____2 mg q 6 hrs PRN
☐ Lorazepam (Antivan) IV _____0.5 mg, _____1 mg q 6 hrs PRN
(Remember that it is a sedative and amnesic effects last about six hours)
☐ Valium PO _____2 mg, _____5 mg, _____10 mg prn q 8 hrs
☐ Haldol IM _____2 mg, _____5 mg q 6 hrs PRN
(Remember, oral-lingual and dyskinetic motion can be controlled by Benadryl 50 mg IV)
☐ Other: _____

For Sleep:
☐ Diphenhydramine (Benadryl) _____ 25 or _____ 50 mg PO qhs PRN sleep
☐ Temazepam (Restoril) _____ 15 or _____ 30 mg PO qhs PRN sleep
☐ Ambien 5 mg PO q hs PRN sleep

For "Sundown Syndrome":
☐ Haloperidol (Haldol) _____1 or _____ 2 mg PO or IM qhs PRN

For Nausea
☐ Phenergan _____12.5 mg or _____ 25 mg IM, IV, or PR q 4-6 hrs prn
☐ Compazine 25 mg PR BID prn
☐ Compazine 10 mg IM q 3 hrs prn
☐ Compazine _____2.5 mg or _____5 mg or _____ 10 mg IV q 3 hrs bid, maximum 40 mg/day
☐ Zofran 4 mg IV q 4 hrs prn

For Constipation:
☐ Milk of Magnesia _____ 30 ml PO q HS prn or _____ q 6 hrs PO prn
☐ Dulcolax Supositories 10 mg PR q hs
☐ Fleets enema per rectum prn

Other Medications/Treatments:

For Diabetics:
_____ Insulin sliding scale orders, q before meals and q HS
If Blood Sugar is

0 – 70,	If patient alert – Orange juice, (If not alert – 1 amp D50 **and** Call House Officer)
71 – 200	Nothing
201 – 250	3 Units of Regular Insulin SQ.
251 – 300	5 Units of Regular Insulin SQ.
301 – 350	7 Units of Regular Insulin SQ.
351 – 400	9 Units of Regular Insulin SQ.
>400	12 Units of Regular Insulin SQ **and** call House Officer.

Atherosclerotic Meds:
☐ Aspirin _____81 mg or _____325 mg PO QD
☐ Plavix (Clopidogrel) _____Loading dose: 375 mg PO x 1
_____ Maintenance dose: 75 mg PO QD
☐ Abciximab (ReoPro) pre-procedure, start _____now, or at _____/_____(date/time)
0.25 microgram / kg IV bolus 10 minutes pre-procedure, then 10 microgram/minute x 12 hours

Date	Time	MD/CNP Name-Please Print	Provider #	Signature	Initial
Date	Time	RN Name - Please Print		Signature	Initial
Date	Time	Clerk Name-Please Pr		Signature	Initial

Patient Identification Label

Meds for patient with true vascular or respiratory "allergic" to contrast material:

☐ Prednisone 50 mg PO (Usually 13 hrs, then 7 hrs, then 1 prior to procedure)
At _____/_____, then _____/_____, then _____/_____ (date/time)
☐ Or _____ Hydrocortisone 100 mg IV 1 hour or immediately prior to procedure
☐ Or _____ Methylprednisolone 125 mg IV 1 hour or immediately prior to procedure
☐ Or _____ Decadron 10 mg IV 1 hour or immediately prior to procedure
☐ **And** _____ Benadryl 50 mg IV _____now, or _____on call to radiology
☐ **And** _____ Cimetidine (Tagamet) 300 mg IV _____now, or _____on call to radiology

Special instructions for patients who are NPO for less than 6 hours prior to a procedure

☐ _____ Reglan (Metoclopramide) 10 mg PO 1 hr prior to procedure or on call to radiology

Home Meds:

DO NOT USE THESE ABBREVIATIONS

U, IU, µG, QOD, MSO4, MgSO4, Trailing zero, Leading decimal point (always use a Leading Zero)

Additional Meds:

Date	Time	MD/CNP Name-Please Print	Provider #	Signature	Initial
Date	Time	RN Name - Please Print		Signature	Initial
Date	Time	Clerk Name-Please Pr		Signature	Initial

Patient Identification Label