ALASKA REGIONAL HOSPITAL

NEURO RADIOLOGY
PRE-PROCEDURE ORDERS

NOTE: ❑ Only those orders checked (" √ ") will be executed. • All orders will be executed.

Patient Name: **Date of Birth:**

DRUG SENSITIVITY: **NKDA ❑**

1. Admission: Reason_____
   - ❑ Admit to Inpatient Status: ❑ SCU ❑ MOU ❑ CCU
   - ❑ Place patient in Outpatient Status (Procedural Recovery): ❑ Recovery ❑ SCU
2. Diagnosis_____ ICD9 Code_____ CPT Code_____
3. Consent for:
   - ❑ Diagnostic Cerebral Angiogram
   - ❑ Stenting of _____
   - ❑ Coiling of _____
   - ❑ Embolization of _____
     - ❑ w/ Particles ❑ w/ Onyx
   - ❑ Vertebroplasty of_____
4. Type of Anesthesia: ❑ General ❑ MAC ❑ Moderate Sedation ❑_____
5. Pre-Procedure: a. Diagnostic Only: start one saline lock left arm (20 g or larger)
   b. Interventional Only: start two saline locks left forearm and AC (18 g & 20 g)
   c. May use buffered lidocaine 1% 0.1 ml intradermally for IV start
6. SCDs and graduated compression stockings; thigh length if planned general anesthesia
7. Foley catheter to be placed in Cath Lab if planned general anesthesia
8. Obtain **weight** of patient day of procedure_____ KG Obtain **height** of patient day of procedure _____ Inches
9. Routine vital signs
10. Diet: NPO after midnight, except for medications with sips of water
11. Lab: ❑ CBC ❑ Chem7 ❑ PT/INR ❑ P2Y12 ❑ PFA
    - ❑ Type & Screen ❑ Type & Cross _____ units ❑ _____ ❑ _____ ❑ _____
    - • Glucose check q 6 hrs for all diabetics on medication BG_____ Time_____
    - • BHCG qual (females childbearing age)
    - • Complete MRSA screening if patient high-risk (I.e. Any transfer from another facility/Hemodialysis admissions/ patients with open-draining wounds)
11. Diagnostic Tests:
    - ❑ EKG ❑ CXR Other_____
12. Fluids:
    - • NS 1000 ml IV at 100 ml/hr **OR**
    - • NS 1000 ml IV at 50 ml/hr if renal insufficiency or dialysis patient
    - ❑ _____
13. Medications:
    - • Acetylcysteine 1200 mg PO pre-procedure if creatinine ≥1.5

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_____

_____ _____ _____

Physician Signature *Date* *Time*

Date	*Time*	❑ T.O. ❑ V.O. Received from: _____ (*LIP) **Order Written, Read Back & Verified by RN:** _____

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PLACE PATIENT LABEL HERE