

Patient Care Order Set

Review Due Date: _____

Angiography Post Sheath Removal Order Set	TRANSCRIPTION
Attending Physician: _____ ***If problems or concerns notify Attending Service, or call Interventional Radiologist at ext. 4347***	
Post procedure	
<input type="checkbox"/> Remove _____ sheath at _____ h.	
Activity	
<input checked="" type="checkbox"/> Maintain bedrest, supine, with head of bed not elevated more than 30 degrees, with punctured limb at rest, and puncture site visible for _____ h	
Vitals/Monitoring	
Vitals Monitoring	
<input checked="" type="checkbox"/> Monitor heart rate continuously during compression <input checked="" type="checkbox"/> Monitor blood pressure q5 min during compression <input checked="" type="checkbox"/> Monitor sheath site and distal pulses q5 – 10 min during compression	
Site Monitoring	
<input checked="" type="checkbox"/> Monitor sheath site (for bleeding or hematoma), heart rate, blood pressure, distal pulses and limb viability: <input checked="" type="checkbox"/> q15 min for 1 hour THEN q30 min for 3 hours	
IV Fluids	
<input type="checkbox"/> 0.9% sodium chloride (0.9% NaCl) _____ mL/h for _____ h THEN service to reassess.	
Discharge	
<input type="checkbox"/> Discharge patient home after completion of bed rest and discontinue IV or saline lock	
Additional Orders	
_____ _____ _____ _____	
Patient may resume eating post procedure	
Prescriber: _____ <div style="display: flex; justify-content: space-between;"> PRINTED NAME DESIGNATION DATE (YYYY/MM/DD) TIME (HHMM) </div>	Pharmacy Use Only: Reviewed By: _____ Entered By: _____ Checked By: _____