



PATIENT CARE ORDERS

Please use black ink ballpoint pen only and press firmly to make copy

Interventional Radiology (IVR) Procedure Order Set (Adult)					TRANSCRIPTION
Weight: _____ kg Adverse Reactions or Intolerances Drug <input type="checkbox"/> No <input type="checkbox"/> Yes (list) _____ Food <input type="checkbox"/> No <input type="checkbox"/> Yes (list) _____ Latex <input type="checkbox"/> No <input type="checkbox"/> Yes					Orders Transcribed Date: _____ (yyyy/mm/dd) Time: _____ (hh:mm)
Pre and During Procedure					_____ PRINT NAME _____ Signature/Discipline
Vitals/Monitoring					_____ Signature/Discipline
Pre-procedure Vitals <input checked="" type="checkbox"/> Baseline Temperature, HR, RR, BP and SpO ₂					Transcription Checked By (must be a nurse) Date: _____ (yyyy/mm/dd) Time: _____ (hh:mm)
Monitoring <input type="checkbox"/> Cardiac Monitoring					_____ PRINT NAME _____ Signature/Discipline
Respiratory					Pharmacy Use Only: Reviewed by: _____ Entered by: _____ Checked by: _____
Oxygen Therapy <input type="checkbox"/> _____ % OR <input type="checkbox"/> _____ liters per minute					Page 1 of 3
Titration <input checked="" type="checkbox"/> Adjust oxygen to: <i>(check one only)</i> <input type="checkbox"/> achieve minimum target SpO ₂ of 92% OR <input type="checkbox"/> achieve minimum target SpO ₂ of _____ <i>(must be less than 92%)</i>					
<input checked="" type="checkbox"/> If SpO ₂ is above target, decrease oxygen by 1 – 2 litres per minute or 10% increments until target achieved <input checked="" type="checkbox"/> Repeat SpO ₂ at least 10 minutes after each oxygen change <input checked="" type="checkbox"/> Discontinue oxygen therapy titration when patient is on room air or home oxygen					
Lab Investigations					
<input type="checkbox"/> Creatinine <input type="checkbox"/> Glucose <input type="checkbox"/> ACT <input type="checkbox"/> Additional Labs: _____					
Diagnostic Imaging					
<input type="checkbox"/> CXR PA and Lateral					
Prescriber Printed Name	Designation	Signature	Date (YYYY/MM/DD)	Time (HHMM):	

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<p>IV Fluids</p> <p>Bolus IV</p> <p><input type="checkbox"/> 0.9% sodium chloride (0.9% NaCl) _____ mL over _____ After bolus IV finished, THEN</p> <p>IV Fluid</p> <p><input type="checkbox"/> 0.9% sodium chloride (0.9% NaCl) _____ mL/h</p>					<p>Orders Transcribed</p> <p>Date: _____ (yyyy/mm/dd)</p> <p>Time: _____ (hh:mm)</p> <p>_____ PRINT NAME</p> <p>_____ Signature/Discipline</p>					
<p>Antimicrobial Prophylaxis</p> <p>Clean procedure (for example, endograft placement)</p> <p><input type="checkbox"/> ceFAZolin 1 gram IV to be administered in the IVR OR</p> <p>If weight greater than 85 kg:</p> <p><input type="checkbox"/> ceFAZolin 2 grams IV to be administered in IVR OR, If history of immediate or accelerated hypersensitivity to beta lactams:</p> <p><input type="checkbox"/> Clindamycin 600 mg IV to be administered in IVR <input type="checkbox"/> Other _____</p> <p>Clean-contaminated or contaminated procedure</p> <p style="color: red;">***For example, embolization/chemoembolization; transjugular intrahepatic portosystemic shunt creation; percutaneous radiologic gastrostomy tube placement, percutaneous nephrostomy tube or ureteric stent placement, percutaneous transrectal biopsy***</p> <p style="color: red;">*** Physician to select single or combination of medications to provide desired antimicrobial spectrum***</p> <p><input type="checkbox"/> ceFAZolin 2 grams IV to be administered in IVR <input type="checkbox"/> MetroNIDAZOLE 500 mg IV to be administered in IVR <input type="checkbox"/> cefTRIAxone 1 gram IV to be administered in IVR OR, If history of immediate or accelerated hypersensitivity to beta lactams:</p> <p><input type="checkbox"/> Clindamycin 600 mg IV to be administered in IVR <input type="checkbox"/> Other _____</p>					<p>Transcription Checked By (must be a nurse)</p> <p>Date: _____ (yyyy/mm/dd)</p> <p>Time: _____ (hh:mm)</p> <p>_____ PRINT NAME</p> <p>_____ Signature/Discipline</p>					
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; height: 20px;"></td> <td style="width:20%; height: 20px;"></td> <td style="width:20%; height: 20px;"></td> <td style="width:20%; height: 20px;"></td> <td style="width:20%; height: 20px;"></td> </tr> </table>										<p>Pharmacy Use Only:</p> <p>Reviewed by: _____</p> <p>Entered by: _____</p> <p>Checked by: _____</p>
Prescriber Printed Name	Designation	Signature	Date (YYYY/MM/DD)	Time (HHMM):	Page 2 of 3					

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Interventional Radiology (IVR) Procedure Order Set (Adult)					TRANSCRIPTION
Nausea Management					Orders Transcribed Date: _____ (yyyy/mm/dd) Time: _____ (hh:mm) _____ PRINT NAME _____ Signature/Discipline
<input type="checkbox"/> dimenhyDRINATE 12.5 – 25 mg PO/IV q4 h prn for nausea <input type="checkbox"/> Ondansetron 4 mg IV q8 h prn for nausea					
PRN Cardiac Medications					
<input checked="" type="checkbox"/> Atropine 0.5 mg IV once prn when indicated by physician <input type="checkbox"/> Labetolol ____ mg IV q10 minutes prn. Titrates to keep systolic BP less than ____ mmHg					
Sedation					Transcription Checked By (must be a nurse) Date: _____ (yyyy/mm/dd) Time: _____ (hh:mm) _____ PRINT NAME _____ Signature/Discipline
<input type="checkbox"/> fentaNYL 25 – 50 mcg IV q3-5 minutes. Titrate to achieve and maintain a Ramsay Sedation Scale (RSS) of 2-3. Maximum dose; 3 mcg/kg total <input type="checkbox"/> Midazolam: 0.5 – 1 mg IV q2-3 minutes. Titrate to achieve and maintain a Ramsay Sedation Scale (RSS) of 2-3. Maximum dose; 3 mg total					
Anticoagulant					
<input type="checkbox"/> Heparin _____ units IV once now <i>(If proceeding with angioplasty)</i>					
Additional Orders					Pharmacy Use Only: Reviewed by: ____ Entered by: ____ Checked by: ____
_____ _____ _____ _____					
_____ _____ _____ _____					
_____ _____ _____ _____					
Prescriber Printed Name	Designation	Signature	Date (YYYY/MM/DD)	Time (HHMM):	Page 3 of 3