(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Order Set Directions:
- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: _____
Allergies with reaction type:_____

ADULT ROUTINE SEIZURE MONITOR ORDERS

Version 5 9/23/2011

Preferred Location: _____

IV SALINE LOCK WITH ROUTINE FLUSH ____YES ____NO

ACTIVITY:
____BRP WITH ASSIST
____UP IN ROOM AS TOLERATED

KEEP PATIENT IN VIDEO CAMERA ANGLE

O2, SUCTION READY AT BEDSIDE

OBTAIN BODY WEIGHT AT ADMISSION

NO INTAKE AND OUTPUT NEEDS TO BE DONE UNLESS OTHERWISE ORDERED SEIZURE PRECAUTIONS

DIET:

TYLENOL (ACETAMINOPHEN) 650 mg. P.O. Q. 4 HOURS PRN MILD PAIN
24 HOUR VIDEO EEG MONITORING

IF PATIENT HAS 2 GENERALIZED TONIC CLONIC SEIZURES OR 4 SEIZURES OF ANY KIND WITHIN 24 HOURS, PAGE ATTENDING PHYSICIAN
FURTHER ORDERS TO FOLLOW

ATTENDANT NEEDED ____YES ____NO
IF YES, WHAT HOURS_____
DR. _____ IS COVERING FROM1700-0700 - MONDAY-THURSDAY

Provider Signature:_____Date:_____Time:_____