(place patient label here)

Patient Name: ____________________________

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: ____

SO ED Extremity Injury Imaging   Version 2   8/27/15

- Activate this Standing Order (SO) by selecting the appropriate provider and using the "Standing Order" order source.

Prior to Ordering Patient Must Meet the Following Criteria

- Injury confined to the extremity
- Presence of deformity, instability, crepitus, point tenderness, ecchymosis, swelling or pain
- Patient request meets above criteria AND
- History of significant or probable fracture
- No imaging of gravid women without provider order (Question all female of childbearing age about possible pregnancy)

Nursing Reminders Prior to Ordering

- Examine injured area and initiate ice, immobilization and elevation
- Palpate joints above and below level of injury to assess for other injuries

Notify Provider for any of the following

- IF analgesia is needed
- IF x-ray of more than one site is needed
- IF any question on which films to order (unable to localize injury)
- IF any associated injury to head, neck or trunk
- IF any evidence of neurovascular compromise

Radiology and Diagnostic Tests: What to Order

"Heard a Pop", inversion or eversion of ankle injury; swelling at malleoli.

- Palpate fifth metatarsal and if pain present, order foot x-ray also. Ankle film does not visualize the metatarsals well.
  - ☐ XR Ankle Complete Reason for exam: ______________________________
    [ ] Left [ ] Right [ ] Bilateral
    Xray to be done portable? [ ] Yes [ ] No

Post traumatic elbow pain if associated with decrease or loss of supination, pronation, flexion, or extension.

- **In a child of 5 years or less with unexplained loss of arm function and no apparent soft tissue swelling, a radial head subluxation must be considered and x-rays should not be obtained prior to physician evaluation
  - ☐ XR Elbow Complete Reason for exam: ______________________________
    [ ] Left [ ] Right
    Xray to be done portable? [ ] Yes [ ] No

If swelling or pain on top of foot

- ☐ XR Foot Complete Reason for exam: ______________________________
  [ ] Left [ ] Right
  Xray to be done portable? [ ] Yes [ ] No

Clear hand injury distal to wrist

- ☐ XR Hand Complete Reason for exam: ______________________________
  [ ] Left [ ] Right
  Xray to be done portable? [ ] Yes [ ] No

Order Special Calcaneal films if fracture suspected

Initials__________

(place patient label here)

Patient Name: ______________________________

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- ☐ XR Calcaneous Reason for exam: ______________________________
  [ ] Left [ ] Right

Inability to stand or walk with localized knee pain OR post traumatic joint effusion OR a fall or blow to the knee area with subsequent inability to flex or extend the knee fully. If pain over patellar area, add order for patellar view

- ☐ XR Knee 3 View Reason for exam: ______________________________
  [ ] Left [ ] Right
  Xray to be done portable? [ ] Yes [ ] No

Tenderness above the shoulder or on top of the shoulder; may or may not have swelling or deformity

- ☐ XR Shoulder Complete Reason for exam: ______________________________
  [ ] Left [ ] Right
  Xray to be done portable? [ ] Yes [ ] No

Fall on an outstretched hand with swelling and tenderness of the wrist

- IF snuffbox tenderness, add a comment of "navicular view" in the additional comments
- ☐ XR Wrist Complete Reason for exam: ______________________________
  [ ] Left [ ] Right
  Xray to be done portable? [ ] Yes [ ] No

Post traumatic pain in hip area if associated with rotated and shortened leg

- ☐ XR Hip Unilateral with Pelvis Reason for exam: ______________________________
  [ ] Left [ ] Right
  Xray to be done portable? [ ] Yes [ ] No

Post traumatic pain in thigh area with swelling or pain to thigh area

- ☐ XR Femur Reason for exam: ______________________________
  [ ] Left [ ] Right
  Xray to be done portable? [ ] Yes [ ] No

Provider Signature:____Date:__________Time:_________