(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
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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 Unilateral Weakness or S/S of Stroke **Version 3 4/29/19**

- Activate this Standing Order (SO) by selecting the appropriate provider and using the "Standing Order" order source.
- Activate this standing order if the patient has a positive BEFAST or unilateral numbness with symptoms less than 24 hours.

Nursing Orders

- ☑ Document time when last neurologically normal
- ☑ Perform National Institutes of Health Stroke Scale (NIHSS) and record score
- ☑ DO NOT DELAY CT scan to obtain ECG or Chest Xray
- ☑ Vital signs non unit standard : on arrival and then BP every 5 minutes x3 then every 15 minutes. HR and neuro check every 15 minutes if less than 3 hours since well.
- ☑ Measure weight now and record in kilograms
- ☑ Cardiac monitor
- ☑ Swallow Screening by nursing prior to oral intake.
- ☑ Aspiration precautions

Respiratory

- ☑ Pulse oximetry continuous
- ☑ Oxygen Delivery via Nasal Cannula at 2 Lpm IF saturation is less than 92%. Titrate as needed to maintain Oxygen saturation greater than 92%

Diet

- ☑ NPO

IV/ Line Insert and/or Maintain

- ☑ Peripheral IV Insert/Maintain

Laboratory

- ☑ CBC/AUTO DIFF
- ☑ COMPREHENSIVE METABOLIC PANEL
- ☑ TROPONIN I
- ☑ PT (PROTIME and INR)
- ☑ PTT
- ☑ LIPID PROFILE
- ☑ UA CULTURE IF INDICATED

IF Female of Menstruating Age and No Hysterectomy Select:

- ☐ PREGNANCY TEST, SERUM

Radiology and Diagnostic Tests

CT Head without Contrast

- ☑ stat Reason for exam: Acute neurological symptoms

DO NOT DELAY CT scan for the following:

ED ECG (ED Provider Only)

- ☑ stat Reason for exam: Stroke Symptoms

- Order chest xray only if indicated for pulmonary or cardiac symptoms

XR Chest single , portable,

- ☐ stat Reason for exam: _____

Initials_____

(place patient label here)

Patient Name: _____

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PROVIDER ORDERS

Consult Provider

- Provider to provider notification preferred.
  - ☑ Consult Tele-Neurology: reason for consult _____
    Does nursing need to contact consulted provider? [ ] Yes [ ] No

Provider Signature:_____Date:_____Time:_____