(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:_____

## ARTERIOGRAM POST-PROCEDURE ORDERS

**Approved by Dept of Radiology Version 4 3/10/2014**

1. Procedure _____.

2. Medications given during procedure:

   A. _____

   B. _____

3. Check _____ site, vital signs, and bilateral pedal pulses q 15 min x 4, q 30 min x 4, q hr x Neuro checks with vital signs if cerebral or carotid angiogram.

4. Report any abnormal bleeding to Dr._____ and Dr._____.

5. Strict bed rest x __ hours. HOB flat. (HOB elevated 15-20 degrees if cannot tolerate laying flat.

6. Keep _____ leg absolutely straight x _____ hours.
7. May log roll side to side.
8. If IV started in X-ray, D/C in 2 hours.

9. Diet:_____

10. Ankle/arm pressure post angioplasty at _____.

    Reports to Dr._____ and Dr._____.

11. ***NOTIFY*** ordering and/or primary physician when procedure is completed.

12. Dr._____ and Dr._____ must see patient prior to discharge.

13. Obtain discharge order from ON CALL radiologist.

14. If patient is taking anticoagulants (i.e., Coumadin, etc.) or Glucophage, primary physician must be contacted before discharge regarding resuming medications.

Provider Signature:_____Date:_____Time:_____