

(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: _____

ARTERIOGRAM PRE-PROCEDURE ORDERS Approved by Dept of Radiology Version 4 3/10/2014

1. Have patient sign authorization form after consultation with the radiologist. A family member or close friend should be present when the radiologist is obtaining the patient's informed consent.
2. Consent to read _____.
3. Clear liquid diet prior to procedure.
4. Continue all previously ordered medications except Heparin or Coumadin. If patient is taking one of these meds, contact the radiologist and the physician who ordered the exam.
5. If the patient is an insulin-dependent diabetic, contact physician regarding appropriate diet and possible adjustment of his insulin dosage.
6. BCS7, CBC, PT, and PTT. Verify with radiologist if needs to be drawn.
7. Start IV with D5.255 NS to run TKO.
8. Void on call to X-ray.

Provider Signature: _____ Date: _____ Time: _____