(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:____

BIOPSY ASPIRATION AND DRAINAGE ORDERS

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

PRE-INTERVENTIONAL RADIOLOGY PROCEDURE

1. LAB: CBC, PT, PTT , BCS7
2. Start IV - Heplock
3. Staff may inject 0.5-2.0 ml of 1% Lidocaine (unless noted allergy) or bacteriostatic saline intradermally at IV site for comfort.
4. Informed consent to read:________________________________

POST-INTERVENTIONAL RADIOLOGY PROCEDURE

1. Procedure ________________________________
2. Medications administered during procedure:

   A. ________________________________C. ______________________

   B ________________________________ D. ______________________

3. Check _________ site, vital signs and temperature q 15 min x 2, q 30 min x 2, q 1 hr x 2.
4. Report any abnormal bleeding, SOB, swelling, or increased pain to

   Dr.________________________ and Dr. ________________________________
   Radiologist Primary

5. Activity: Bed rest x 2-4 hours with BRP.
6. Diet ____
7. ____________________ X-ray TF @ _____________________________
   Date/Time
8. Empty drainage bag and record output.
9. Change dressing PRN.
10. Discharge at: ____

    ____

    ____

Provider Signature:____Date:__________Time:_________