MOUNT AUBURN HOSPITAL
330 Mount Auburn Street
Cambridge, MA 02138

Uterine Artery Embolization Physician Orders

Patient Stamp

IMPORTANT: PLEASE WRITE LEGIBLY. Orders with a Box ☐ Require a Checkmark to Activate

MEDICATION ORDERS	OTHER ORDERS
☐ IV NS@)______ml/hr.	
☐ PCA: See PCA Order Sheet ☐ Ondansetron (Zofran) 4 mg IV q 4 hours prn for nausea or vomiting ☐ Ketoralac (Toradol) 30 mg IV at ________(6 hours after initial dose) and repeat dose at ____________. ☐ Ibuprofen (Motrin) 800 mg PO TID starting at _____.	☐ Admit to observation Allergies: ☑ Assess and record vital signs following protocol for post procedure moderate sedation. One set of vital signs when patient returns to room after procedure completed, then resume routine vital signs. ☑ With vital signs check _________groin puncture site for bleeding or hematoma. ☑ Bedrest with _____leg straight x 4 hrs. May elevate HOB 20 degrees for meals. May sit up and ambulate at ___________. ☐ Regular diet - advance as tolerated. Start with clear to full liquids. ☑ Foley catheter to gravity drainage bag. Discontinue at _____PM, DTV 8-10 hrs, may straight cath x 1 if unable to void. ☑ For questions call Interventional Radiology at x 5798. Any problems after 17:00 call the radiology resident on call.

Physician Signature: ________________________________ **Date:** ____ **Time:** ______ **Beeper:** ________

Printed Name: ____________________________________

RN Signature: _____________________________________ **Date:** ____ **Time:** ______ **Fax Time:** _____

RN Printed Name___________________________________