

PHARMACY ORDERS MUST CONTAIN

IV ACCESS

**DATE-TIME-NAME OF MEDICATION-DOSE-ROUTE
 FREQUENCY-DURATION-NO SIGNATURE-PERMISSION
 IS GIVEN TO DISPENSE THE GENERIC THERAPUETIC
 EQUIVALENT**

- Peripheral
- Hickman I Lumen
- Hickman II Lumen
- Hickman III Lumen
- CVP
- Port A Cath Single
- Port A Cath Double
- Groshong Single
- Groshong Double
- Other

ALLERGIES

DIAGNOSIS

HT:

WT:

BSA:

DATE

TIME

POST CATH ORDERS

Circle number of prescribed order. Omitted orders are to be crossed out with a single line and initialed.

1. Record vital signs as follows:
Every 15. mins. X 1 hr or until stable; Every 30 mins x 2, then every 4hrs
2. Check access site for bleeding or hematoma every 1hr; if present apply pressure to site and call cath lab and / physician immediately.
_____ Antecubital Right / left groin _____
3. Check pulses, color and temperature of extremities hourly x 6hrs. Notify physician if extremity is discolored, becomes cool or pulse diminishes.
4. Notify physician if BP less than _____ systolic, or pulse greater than _____ BPM, or less than _____ BPM.
5. Raise foot of bed if patient becomes hypotensive and remove sandbag if present. Notify physician immediately.
6. Check patient for hives, itching or wheezing. Notify physician immediately.
7. Activity: complete bed rest for 6hrs; may elevate HOB 30-35 degrees. Sandbag to _____ groin x _____ hrs then remove.
8. Diet. Encourage po fluids. Diet as tolerated _____.
9. Medications:
Resume previous medication order.
_____ every 4hrs PRN pain from cath side.
_____ every 4hrs PRN nausea.
_____ for hives or itching.
10. Straight cath if unable to void.
11. IV fluids at _____ mL per hr, discontinue when pt is able to tolerate PO fluids.
12. Discharge patient at _____ am / pm
Ambulate patient prior to discharge, check cath site, if any bleeding or hematoma is Noted, apply pressure to site and inform physician.

LOCATION:

EPISODE# :

All original UMSylvester medical records are the property of UMSylvester and maintained by the Health Care Provider's Record Custodian. Copies of this form must be destroyed upon the completion of its temporary use. To receive a copy of your health information please contact your Health Care Provider's Record Custodian or the UMSylvester HIM Release of Information department at (305) 243-5272.

**SYLVESTER COMPREHENSIVE CANCER CENTER
 UNIVERSITY OF MIAMI HOSPITAL & CLINICS**

Miami, FL 33136 www.med.miami.edu (305)243-1000

POST- CATH ORDER SHEET

NAME: _____

_____ UMMG # MRN

AGE: _____ **DOB:** _____ / _____ / _____

DATE OF SERVICE: _____



Form
A1400015

Revised
3/16/05