

PHARMACY ORDERS MUST CONTAIN

IV ACCESS

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

- | | |
|--|---|
| <input type="checkbox"/> Peripheral | <input type="checkbox"/> Port A Cath Single |
| <input type="checkbox"/> Hickman I Lumen | <input type="checkbox"/> Port A Cath Double |
| <input type="checkbox"/> Hickman II Lumen | <input type="checkbox"/> Groshong Single |
| <input type="checkbox"/> Hickman III Lumen | <input type="checkbox"/> Groshong Double |
| <input type="checkbox"/> CVP | <input type="checkbox"/> Other |

ALLERGIES

DIAGNOSIS

HT:

WT:

BSA:

DATE

TIME

PRE-CATH ORDERS

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

1. Patient scheduled for: _____ Date _____ Time _____
2. Ensure that authorization for procedure is in medical records.
3. **LAB WORK: PT,PTT,CBC, Platelet, SMA7 – Basic Chemistry**
 Results available for procedure, inform physician of abnormal results.
Note: No blood drawing from antecubital vein of right arm. Record height and weight on front of chart.
4. **Dietary restrictions:**
 Clear liquid breakfast then NPO
 NPO after _____ (date/time) except meds.
 Other _____
5. 12 Lead EKG should be done, have copy available on chart.
6. Shave and prep both groins.
7. Start IV (solution) _____ @ _____ mL/hr _____
 on _____ (date/time)
8. Meds: Continue all meds except _____
9. Premedications on call to cath lab: medication/dose/route _____
10. Inform Physician of iodine or seafood allergy prior to procedure
Patients with iodine/seafood allergy:
 Solumedrol, _____ mgs or Solucortef _____ mgs IVP
 Zantac/Tagement, _____ mgs IVP : Benadryl _____ mgs IVP

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

PRE-CATH ORDER SHEET

NAME: _____

UMMG # MRN

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

DATE OF SERVICE: _____



Form
A1400016

Revised
3/16/05