



PLACE LABEL HERE.
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

PHYSICIAN'S ORDERS - MYELOGRAM & CISTERNOGRAM

WRITE FIRMLY - USE BALL POINT PEN

MEDICATION AND I.V. ORDERS ONLY		
ALL orders must be written in the metric system and include date, time, drug, strength, route, dosage schedule, and physician's signature.		
Date	Time	Drug
M.D.		
Date	Time	Drug
M.D.		
Date	Time	Drug
M.D.		
Date	Time	Drug
M.D.		
Date	Time	Drug
M.D.		
Date	Time	Drug
M.D.		
Date	Time	Drug
M.D.		
Date	Time	Drug
M.D.		

PHYSICIAN'S ORDERS (EXCLUDING MEDICATION ORDERS)
Date _____
Myelogram & Cisternogram Orders
Pre-Procedure
<ul style="list-style-type: none"> ● No solid food for 3 hours prior to procedure. ● Liquids up to time of procedure. ● D/C 48 hours prior to procedure all medications listed on the Myelogram restricted drug list. ● Check ID Band. ● Dress in hospital gown. ● Check & record: BP, P, R, T, & SAO2. ● Check PT, PTT, PLTS if on anticoagulants or has Bleeding Dyscrasia. Report abnormalities to MD.
MD _____
Time _____ Date _____
Post-Procedure
Puncture time: _____
<ul style="list-style-type: none"> ● Check & record: BP, P, R, T, & SAO2. ● Give patient PO liquids. ● Assess puncture site for swelling and drainage. ● Patient should not restart any medication listed on Myelogram restricted drug list for 24 hours following the time of contrast injection. ● Review appropriate discharge orders with patient/ caregiver. ● Must have driver. ● May not drive until the next day. ● Discharge home after physician's clearance.
MD _____
Time _____ Date _____

Name: _____
 History Number: _____
 Date of Service: _____

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Pre-Procedure Assessment

Date: _____ Time: _____ Procedure: Myelogram Other _____ Department: Neuro-Radiology

Allergies: _____ **Latex:** Yes No

Isolation: Yes No Type: _____

Accompanied by: _____ Location: _____

Pre-Procedure Patient Education: <input type="checkbox"/> Procedure <input type="checkbox"/> Other <input type="checkbox"/> Verbal Instruction upon arrival by MD/ Nurse <input type="checkbox"/> Written Consent	Indication of Patient's Understanding: <input type="checkbox"/> Verbal Response <input type="checkbox"/> Asked Questions <input type="checkbox"/> Further Instructions Required
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Reason for Procedure (Patient's own words): _____

Current Medications	Dosage	Last Dose	Current Medications	Dosage	Last Dose

Vital Signs: BP _____ HR _____ R _____ SAO2 _____ T _____

Dietary: Solid Food _____

ID Band: Applied _____ Confirmed _____ **Valuables removed:** Yes No

Patient Voided @ _____ **Properly Attired:** Yes No

Are you pregnant? Yes No N/A **LMP:** _____

Comments: _____

Signature: _____

Post-Procedure Evaluation

Time: _____ **Vital Signs:** BP _____ HR _____ R _____ SAO2 _____

Procedure Site Check: Without redness or swelling

Headache Nausea Other Discomfort

Comments: _____

Patient Education: Post-Procedure Other

Written Standardized Discharge Form Given: Yes No

Further Instructions Needed: Yes No

Patient instructed to call for problems, questions, concerns: Yes No N/A

Patient Discharged by Dr. _____ @ _____

Mode: Ambulatory Wheelchair Stretcher Other

Comments: _____

Signature: _____