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POST-PROCEDURE:

☐ Sheath Puncture Site 1: _____ Time Removed: _____ Hemostasis Time: _____ ☐ ACT _____ seconds @ _____

☐ Sheath Puncture Site 2: _____ Time Removed: _____ Hemostasis Time: _____ ☐ Closure Device Site: _____ @ _____

TIME	BP	P	R	LOC	O2 sat	O2	PAIN	L DP/PT	R DP/PT	NO BLEED / HEMATOMA	MEDICATIONS	COMMENTS / INITIALS

TOTALS: Maintenance IV Fluid _____ Other _____ Antibiotics _____ Contrast _____ Other _____ Blood _____ Fentanyl _____ Versed _____ Heparin _____ Total Intake _____ Total Output _____

	TIME	RES	CIR	SK	LOC	ACT	TOTAL
POST-PROCEDURE							
PRIOR TO DISCHARGE FROM SEDATION							

DISCHARGE / TRANSFER CRITERIA MET:

☐ VS, O2 SAT, Aldrete Score Stable / WNL of pre-sedation baseline ☐ Level of consciousness at pre-sedation baseline

☐ Airway protective reflexes intact / WNL of pre-sedation baseline Transferred to _____

Hand off report to _____ Time _____

Disposition: ☐ Discharged ☐ Admitted/Transferred Time: _____

Belongings: ☐ With Patient ☐ Given to Significant Other ☐ N/A

Mode: ☐ Stretcher ☐ Bed ☐ Wheelchair ☐ Ambulatory ☐ Ambulance

Accompanied By: ☐ Family ☐ Friend/Other ☐ Nurse ☐ Transportation

OUTCOMES: (check all that apply)

☐ Apnea > 15 seconds ☐ Unplanned tracheal intubation or positive pressure ventilation

☐ Oxygen desaturation for > 90 seconds to < 90% O2 SAT (or >/= 8% O2 SAT drop from baseline)

☐ Unexpected change in HR, BP, RR, to 30% above or below baseline

☐ Unplanned use of reversal agent ☐ Vomiting (non-GI procedure)

☐ Emergency anesthesia consultation after procedure begun ☐ None of the above occurred

Signature	Print Name	Initials	Date	Time

SIGNATURE _____ **MD PA NP PIC #** _____ **Date** _____ **Time** _____

Immediate Re-Evaluation, Medication Orders (circle)

UNIVERSITY OF VIRGINIA HEALTH SYSTEM

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PLACE LABEL HERE.

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

NURSING INTERVENTIONAL RADIOLOGY PROCEDURAL FLOWSHEET

Date _____ Time _____ ☐ ADM ☐ OP ☐ INPT _____ ☐ Armband / ID Confirmed

Procedure _____ RN _____ Initials _____

Transportation provided by: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Location: _____

BP_____ Pulse _____ Resp _____ Temp_____ O2 Sat_____ O2 Mode_____

Allergies:_____ ☐ Contrast ☐ Latex

NEUROLOGICAL:

☐ Alert ☐ Drowsy ☐ Lethargic ☐ Comatose Oriented: ☐ X1 ☐ X2 ☐ X3

Behavior / Affect: ☐ Appropriate ☐ Flat ☐ Agitated ☐ Anxious Restraints: ☐ No ☐ Yes

Movement & Sensation: ☐ Intact ☐ Impaired Communication Barrier: ☐ No ☐ Yes ☐ Cyracom Phone ☐ Interpreter

Comments: _____

PAIN ASSESSMENT:

Pain Management: ☐ N/A ☐ PRN Analgesia ☐ Scheduled Analgesia ☐ PCA ☐ Epidural

Is the patient currently having pain? ☐ No, pain not an issue ☐ No, management effective

☐ Yes Location: _____ Rating:_____ Goal:_____

Pain Scale: ☐ Verbal Descriptive ☐ Numeric ☐ Visual Analogue

Duration: ☐ Chronic ☐ Acute ☐ Constant ☐ Intermittent ☐ Other Character: ☐ Stabbing ☐ Burning ☐ Sharp ☐ Dull ☐ Ache ☐ Other

Comments: _____

RESPIRATORY:

Spontaneous Respirations: ☐ Regular ☐ Irregular ☐ Unlabored ☐ Labored ☐ Symmetrical ☐ Asymmetrical

Oxygen Required: ☐ No ☐ Yes Frequency: ☐ PRN ☐ Continuous Rate _____

Oxygen Delivery: ☐ Nasal Cannula ☐ Face Tent ☐ Venti Mask ☐ Non-Rebreather ☐ Trach Collar

Trach Size _____ Stoma: ☐ Intact ☐ Pink ☐ Red ☐ Excoriated Cuff: ☐ Inflated ☐ Deflated ☐ NA

Does the patient have sleep apnea? ☐ No ☐ Yes CPAP? ☐ No ☐ Yes Can the patient lie flat? ☐ No ☐ Yes

Comments: _____

CARDIOVASCULAR:

Rhythm: ☐ Regular ☐ Irregular ☐ Paced ☐ AICD Edema: ☐ No ☐ Yes EKG: ☐ N/A ☐ Yes

Pulses (0 - 4+) ☐ N/A DP / PT R ____ _/_____ DP / PT L ____ _/_____

Comments: _____

MUSCULOSKELETAL / MOBILITY:

Gait: ☐ Steady ☐ Unsteady ☐ Unable to Ambulate Assistive Device: ☐ N/A ☐ Cane ☐ Walker ☐ Wheelchair ☐ Stretcher

Transfers: ☐ Independent ☐ Standby Assist ☐ Mod Assist ☐ Max Assist

Diligent Equipment Used: ☐ N/A ☐ Stedy ☐ Encore ☐ Tempo ☐ Maxi Slides ☐ Transfer Tube

Comments: _____

GASTROINTESTINAL:

Dietary Status: ☐ No solid food in preceding 6 hours and no liquid in preceding 2 hours ☐ NPO after midnight

Accucheck: ☐ N/A Preprocedure _____ ☐ Biliary Tube ☐ Capped ☐ Straight Drain

☐ NG / Salem Sump ☐ Feeding Tube / Dobhoff ☐ PEG / PEJ ☐ Clamped ☐ Suction ☐ Gravity

Comments: _____

GENITOURINARY:

☐ Voids ☐ Supra Pubic ☐ Foley ☐ Ileo Conduit ☐ Anuric

☐ Neph Tube ☐ Right ☐ Left ☐ Capped ☐ Straight Drain

☐ Dialysis: ☐ Peritoneal ☐ Hemodialysis ☐ Fistula ☐ R ☐ L ☐ Thrill ☐ Bruit Last dialyzed _____

Comments: _____

INTEGUMENTARY:

☐ Intact ☐ Breakdown ☐ Pressure Sore ☐ Ecchymosis ☐ Rash

Comments: _____

INTRAVENOUS SOLUTIONS:

- ☐ Arrives with Access: ____________________
- ☐ New Access: ____________________
- ☐ Normal Saline 0.9% 250 ml Time: ________ Rate: ________ RN Initials: ________
- ☐ Normal Saline 0.9% 1000 ml Time: ________ Rate: ________ RN Initials: ________
- ☐ .45 Normal Saline 1000 ml Time: ________ Rate: ________ RN Initials: ________
- ☐ Sodium Bicarbonate 150 MEQ/ 5% Dextrose 1000 ml Time: ________ Rate: ________ RN Initials: ____/_____
- ☐ Lactated Ringers 1000 ml Time: ________ Rate: ________ RN Initials: ____/_____
- ☐ Tissue Plasminogen Activase 10 mg/ 500ml Normal Saline Time: _______ Rate: _______ RN Initials: ____/_____
- ☐ Tissue Plasminogen Activase 20 mg/ 100ml Normal Saline Time: _______ Rate: _______ RN Initials: ____/_____
- ☐ Heparin 25,000 units/ 250 ml 5% Dextrose Water Time: ________ Rate: ________ RN Initials: ____/_____
- ☐ Heparin 1000 units/ 500 ml 0.9% Normal Saline Time: ________ Rate: ________ RN Initials: ____/_____
- ☐ Other: ____________________ Time: ________ Rate: ________ RN Initials: ____/_____
- ☐ Other: ____________________ Time: ________ Rate: ________ RN Initials: ____/_____

PRE-PROCEDURE MEDICATIONS:

Medication: ____________________ Time: ________ Dose: ________ Route: ________ RN Initials: ________

Medication: ____________________ Time: ________ Dose: ________ Route: ________ RN Initials: ________

Medication: ____________________ Time: ________ Dose: ________ Route: ________ RN Initials: ________

Medication: ____________________ Time: ________ Dose: ________ Route: ________ RN Initials: ________

Medication: ____________________ Time: ________ Dose: ________ Route: ________ RN Initials: ________

Medication: ____________________ Time: ________ Dose: ________ Route: ________ RN Initials: ________

ALDRETE SCORE:

RESpirations:	**2 = Able to deep breathe & cough**	**1 = Regular, quiet, adequate**	**0 = Obstructed, noisy, inadequate**
CIRculation:	**2 = + / - 20% pre-op**	**1 = + / - 20-50% of pre-op**	**0 = + / - 50% of pre-op**
SKin:	**2 = Normal color / dry**	**1 = Flushed, pale, diaphoretic**	**0 = Dusky, cyanotic**
LOC:	**2 = Alert & oriented**	**1 = Arousable by voice**	**0 = Not responsive**
ACTivity:	**2 = Purposeful movement 4 extrm.**	**1 = Non-purposeful**	**0 = Not moving extremities**

	TIME	RES	CIR	SK	LOC	ACT	TOTAL
PRE-PROCEDURE							

EQUIPMENT READINESS:

- ☐ Port protocol followed
- ☐ In room for moderate / deep sedation: O2, Bag / Mask, Pulse Oximeter, Suction, BP Monitor
- ☐ In area moderate sedation / in room deep sedation: Airway Box, Cardiac Monitor, Emergency Medications
- ☐ In area for moderate / deep sedation: Code Cart, Defibrillator
- ☐ Time out completed

Patient Shielding: ☐ NA ☐ Mucomist to back ☐ Pelvis ☐ Eye Shielding

LOC Scale: 5 - Awake / Alert 4 - Sleeping Intermittently 3 - Asleep, Responds to Voice
2 - Responds to Painful Stimuli 1 - Unresponsive

EKG STRIP:

INTRA PROCEDURE:

TIME	BP	P	R	LOC	O2 sat	O2	PAIN	Versed mg/IV	Fentanyl mcg/IV	MEDICATIONS	COMMENTS / INITIALS
TIME: _______________ **PATIENT RE-EVALUATED** by LIP immediately prior to sedation and procedure											

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PLACE LABEL HERE.

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

TIME	BP	P	R	LOC	O2 sat	O2	PAIN	Versed mg/IV	Fentanyl mcg/IV	MEDICATIONS	COMMENTS / INITIALS