Myelogram, Post Procedure Discharge  [30401538]

<table>
<thead>
<tr>
<th>Myelogram, Post Procedure Discharge  [30401538]</th>
</tr>
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<tbody>
<tr>
<td>When patient returns to diagnostic imaging, begin the following</td>
</tr>
</tbody>
</table>

**Height**_____________________
**Weight**_____________________  
**Allergies**_____________________

**General - Prior to Discharge**

**Vital Signs**

[X] Vital signs
Routine, Every 30 min, Starting today, Upon return from Diagnostic Imaging, then every 30 minutes, Post-Procedure

**Notify Provider**

[X] Notify physician
Routine, Until discontinued, Starting today
Pulse greater than:
Respiratory rate less than:
Respiratory rate greater than:
Temperature greater than (celsius):
Urine output less than (mL/hr):
Systolic BP greater than:
Systolic BP less than:
Diastolic BP greater than:
Diastolic BP less than:
Other:
Notify Radiologist in Diagnostic Imaging who performed the procedure of severe headaches, seizures, unusual symptoms, or change in neurologic assessment., Post-Procedure

**Activity**

[X] Sit Upright
Routine, As needed, Starting today, Keep patient sitting upright in chair of bed for one hour post procedure at 45-50 degrees. Avoid excessive movement for first hour post procedure., Post-Procedure

[X] Bathroom privileges
Routine, Until discontinued, Starting today, Post-Procedure

**Nursing**

[X] Neuro checks
Routine, Now then every 1 hour, Starting today, With vital signs every hour, Post-Procedure

[ ] Saline lock IV
Routine, Continuous, Starting today, When patient taking PO fluids., Post-Procedure

[ ] Discontinue IV
Routine, Continuous, Starting today, When taking adequate PO fluids, Post-Procedure

**Discharge Instructions - Prior to Discharge**

[X] Discharge instructions
Routine, Once, Starting today, Discharge patient when discharge criteria is met, Post-Procedure

[X] Patient education
Routine, Once, Starting today, Review with patient post myelogram instruction sheet, Post-Procedure

[ ] Discharge instructions
Routine, Once, Starting today, Post-Procedure

**General - AMB Orders - Post Discharge**

**Activities - Discharge**

[ ] Wound care
Routine, Clinic Performed, Post Discharge

[ ] Activity as tolerated
Routine, Clinic Performed, Post Discharge

**Provider Initial:**_____________________

Page 1 of 2
Myelogram Post Procedure Discharge  [30401538]
## PHYSICIAN ORDERS

### Discharge activity
- [ ] Routine, Clinic Performed, Post Discharge
- [ ] Routine, Clinic Performed, Post Discharge

### Diet - Discharge
- [ ] Routine, Clinic Performed, Post Discharge
- [ ] Routine, Normal, Post Discharge

### Education - Discharge
- [ ] Routine, Clinic Performed, Post Discharge
- [ ] Routine, Clinic Performed, Post Discharge

### Discharge Instructions - Post Discharge
- [ ] Routine, Clinic Performed, Post Discharge

### IV Fluids - Prior to Discharge

<table>
<thead>
<tr>
<th>Item</th>
<th>Order Details</th>
</tr>
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<tbody>
<tr>
<td>sodium chloride 0.9% (NS) infusion</td>
<td>75 mL/hr, IntraVENous, Continuous, For 2 Hours, Post-Procedure, Routine</td>
</tr>
<tr>
<td>sodium chloride 0.9 % (NS) flush syringe</td>
<td>2 mL, IntraVENous, Every 8 hours interval, Post-Procedure, Flush peripheral line Routine</td>
</tr>
</tbody>
</table>

### Medications - Prior to Discharge

<table>
<thead>
<tr>
<th>Item</th>
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</tr>
</thead>
<tbody>
<tr>
<td>acetaminophen (TYLENOL) tablet</td>
<td>650 mg, Oral, Every 6 hours PRN, headaches, Post-Procedure, Routine</td>
</tr>
<tr>
<td>oxyCODONE-acetaminophen (PERCOCET) tablet 5-325 mg</td>
<td>1-2 tablet, Oral, Once as needed, severe pain, For 1 Doses, Post-Procedure, Routine</td>
</tr>
<tr>
<td>HYDROcodone-acetaminophen (VICODIN) tablet 5-325 mg</td>
<td>1-2 tablet, Oral, Once as needed, moderate pain, For 1 Doses, Post-Procedure, Routine</td>
</tr>
</tbody>
</table>

### Medication - AMB Orders - Post Discharge

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<tbody>
<tr>
<td>ACETAMINOPHEN 325 MG TABLET</td>
<td>Normal</td>
</tr>
<tr>
<td>OXYCODONE-ACETAMINOPHEN 5 MG-325 MG TABLET</td>
<td>Print</td>
</tr>
<tr>
<td>HYDROCODONE-ACETAMINOPHEN 5 MG-325 MG TABLET</td>
<td>Print</td>
</tr>
</tbody>
</table>

Date:_______ Time:_______ Printed Name of Ordering Provider:________________________________________________________

Provider Signature:_______________________________________________________________________________________

Date:_______ Time:_______ RN Acknowledged:____________________________________________________________________