ED Advanced Abdominal Pain/Flank Pain (1556)

Version: 13 **Gen:** 11/3/2026

Location: _____

General

Nursing

Vital Signs

☐ **Vital signs - T/P/R/BP** **Frequency:** Per unit protocol **Priority:** Routine

☐ **Orthostatic vital signs** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** STAT **Comments:** If patient is able to stand

Nursing

☐ **ED bedside monitoring** **Frequency:** Continuous **Priority:** STAT

Diet

☑ **NPO** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
NPO:
Pre-Operative fasting options:
Process Instructions:
An NPO order without explicit exceptions means nothing can be given orally to the patient.

IV Fluids

Peripheral IV Access

☑ **Initiate and maintain IV**

☑ **Insert peripheral IV** **Frequency:** Once **Priority:** Routine

☑ **sodium chloride 0.9 % flush** **Dose:** 10 mL **Frequency:** every 12 hours scheduled **PRN Reasons:** line care
Question(s):
Indication(s) for Once Reason:

☑ **sodium chloride 0.9 % flush** **Dose:** 10 mL **Route:** intravenous **Frequency:** PRN **PRN Reasons:** line care
Question(s):
Indication(s) for Once Reason:

IV Fluids

☐ **sodium chloride 0.9 % bolus 1000 mL** **Dose:** 1000 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT **Minimum Infusion Duration:** 30.000 Minutes
Question(s):
Indication(s) for Once Reason:

☐ **sodium chloride 0.9 % bolus 500 mL** **Dose:** 500 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT **Minimum Infusion Duration:** 15.000 Minutes
Question(s):
Indication(s) for Once Reason:

☐ **sodium chloride 0.9 % infusion - 100 mL/hr** **Dose:** 100 mL/hr **Route:** intravenous **Frequency:** continuous **Priority:** STAT
Question(s):
Indication(s) for Once Reason:

Medications

Antibiotics

☐ **cefazolin (ANCEF) IV** **Dose:** 1 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Type of Therapy: New Anti-Infective Order
Reason for Therapy: Bacterial Infection Suspected
Indication: Uro/Genital
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:

☐ **cefTRIAxone (ROCEPHIN) IV** **Dose:** 1 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Type of Therapy: New Anti-Infective Order
Reason for Therapy: Bacterial Infection Suspected
Indication: Uro/Genital
Indication:
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **metronidazole (FLAGYL)** **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication:

☐ **Penicillin/Beta-Lactam allergy: ciprofloxacin (CIPRO) IV** **Dose:** 400 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Type of Therapy: New Anti-Infective Order
Reason for Therapy: Bacterial Infection Suspected
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Product Admin Instructions:
May cause QTc prolongation.

☐ **Penicillin/Beta-Lactam allergy: levofloxacin (LEVAQUIN) IV** **Dose:** 750 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Type of Therapy: New Anti-Infective Order
Reason for Therapy: Bacterial Infection Suspected
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication:
Product Admin Instructions:
May cause QTc prolongation.

☐ **nitrofurantoin (macrocrystal-monohydrate) (MACROBID) 100 MG capsule** **Dose:** 100 mg **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:

☐ **sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Type of Therapy: New Anti-Infective Order
Reason for Therapy: Bacterial Infection Suspected
Indication: Uro/Genital
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:

Severe Pain (Pain Score 7-10)

○ **morPHINE injection** **Dose:** 4 mg **Route:** intravenous **Frequency:** once PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if patient c/o pain is GREATER than or equal to 7, is not hypotensive and does not have an allergy to morphine.

○ **HYDROmorphone (DILAUDID) injection** **Dose:** 0.5 mg **Route:** intravenous **Frequency:** once PRN **Priority:** STAT **PRN Reasons:** severe pain (score 7-10)

General Medications

☐ **lidocaine/maalox (GI COCKTAIL) suspension** **Dose:** 30 mL **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
SHAKE WELL BEFORE USE

☐ **pantoprazole (PROTONIX) injection** **Dose:** 40 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

Antiemetics

☑ **ondansetron (ZOFRAN) IV or Oral** (Required)

Sign:_____ **Printed Name:**_____
Date/Time:_____

◉ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet** **Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
May cause QTc prolongation.

◉ **ondansetron (ZOFRAN) 4 mg/2 mL injection** **Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Product Admin Instructions:
May cause QTc prolongation.

☐ **promethazine (PHENERGAN)**

◉ **promethazine (PHENERGAN) 12.5 mg IV** **Dose:** 12.5 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

◉ **promethazine (PHENERGAN) tablet** **Dose:** 12.5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

◉ **promethazine (PHENERGAN) suppository** **Dose:** 12.5 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

◉ **promethazine (PHENERGAN) intraMUSCULAR injection** **Dose:** 12.5 mg **Route:** intramuscular **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

Antiemetics

☑ **ondansetron (ZOFRAN) IV or Oral** (Required)

◉ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet** **Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
May cause QTc prolongation.

◉ **ondansetron (ZOFRAN) 4 mg/2 mL injection** **Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Product Admin Instructions:
May cause QTc prolongation.

☐ **promethazine (PHENERGAN) IV or Oral or Rectal**

Sign:_____ **Printed Name:**_____
Date/Time:_____

◉ **promethazine (PHENERGAN) injection Dose:** 12.5 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

◉ **promethazine (PHENERGAN) tablet Dose:** 12.5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is able to tolerate oral medication.

◉ **promethazine (PHENERGAN) suppository Dose:** 12.5 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

Antiemetics

☑ **ondansetron (ZOFRAN) IV or Oral** (Required)

◉ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
May cause QTc prolongation.

◉ **ondansetron (ZOFRAN) 4 mg/2 mL injection Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Product Admin Instructions:
May cause QTc prolongation.

☐ **promethazine (PHENERGAN) IVPB or Oral or Rectal**

◉ **promethazine (PHENERGAN) 25 mg in sodium chloride 0.9 % 50 mL IVPB Dose:** 12.5 mg **Route:** intravenous **Frequency:** every 6 hours PRN **Minimum Infusion Duration:** 30.000 Minutes **PRN Reasons:** nausea
vomiting
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

◉ **promethazine (PHENERGAN) tablet Dose:** 12.5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is able to tolerate oral medication.

◉ **promethazine (PHENERGAN) suppository Dose:** 12.5 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

Labs

Laboratory STAT

☐ **CBC with differential Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **Prothrombin time with INR** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Basic metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Comprehensive metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Amylase** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lipase** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatic function panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lactic acid level - Now and repeat 2x every 2 hours** **Frequency:** Now and repeat 2x every 2 hours **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** STAT - SPECIMEN MUST BE DELIVERED IMMEDIATELY TO THE LABORATORY. Repeat Lactic acid in 2 hours. Cancel repeat lactic acids if initial or subsequent result is less than or equal to 2.0. Notify physician if lactic acid is greater than 2.0.

☐ **Venous blood gas** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Beta hydroxybutyrate** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Troponin T** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Urinalysis screen and microscopy, with reflex to culture** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine
Question(s):
Specimen Source: Urine
Specimen Site:
Primary Ordering Comments:
Specimen must be received in the laboratory within 2 hours of collection.

☐ **Type and screen** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood

Laboratory

☐ **CBC with differential** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Prothrombin time panel I-Stat** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood

☐ **Basic metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Comprehensive metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Amylase** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lipase** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatic function panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lactic acid, I-Stat** **Frequency:** Now then every 2 hours **Frequency Limit:** 3 Occurrences **Priority:** STAT **Specimen Type:** Blood **Comments:** STAT - SPECIMEN MUST BE DELIVERED IMMEDIATELY TO THE LABORATORY. Repeat Lactic acid in 2 hours. Cancel repeat lactic acids if initial or subsequent result is less than or equal to 2.0. Notify physician if lactic acid is greater than 2.0.

☐ **Venous blood gas** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Beta hydroxybutyrate** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Troponin , I-Stat** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **Urinalysis screen with reflex to culture** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine
Question(s):
Specimen Source: Urine
Specimen Site:
Primary Ordering Comments:
Specimen must be received in the laboratory within 2 hours of collection.

☐ **Type and screen** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood

Laboratory

☐ **CBC with differential** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Prothrombin time panel I-Stat** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood

☐ **Basic metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Comprehensive metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Amylase** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lipase** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatic function panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lactic acid level - Now and repeat 2x every 2 hours** **Frequency:** Now and repeat 2x every 2 hours **Frequency Limit:** 3 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** STAT - SPECIMEN MUST BE DELIVERED IMMEDIATELY TO THE LABORATORY. Repeat Lactic acid in 2 hours. Cancel repeat lactic acids if initial or subsequent result is less than or equal to 2.0. Notify physician if lactic acid is greater than 2.0.

☐ **Venous blood gas** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Beta hydroxybutyrate** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Troponin, I-Stat** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood

☐ **Urinalysis screen with reflex to culture** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine
Question(s):
Specimen Source: Urine
Specimen Site:
Primary Ordering Comments:
Specimen must be received in the laboratory within 2 hours of collection.

☐ **Type and screen** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood

GU/Pelvic Labs STAT

☐ **Chlamydia trachomatis, NAA** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine
Question(s):
Specimen Source:
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Neisseria gonorrhoeae, NAA** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine
Question(s):
Specimen Source:
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Rhogam Type and Screen** **Frequency:** Once **Priority:** STAT **Specimen Type:** Blood

☐ **Wet prep** **Frequency:** Once **Priority:** STAT
Primary Ordering Comments:
Deliver specimen immediately to the Core Laboratory.

Pregnancy Labs

☐ **hCG QUALitative, serum** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **hCG QUALitative, urine** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Urine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **hCG QUANtitative, serum** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** STAT **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Cardiology

Cardiology

☐ **ECG 12 lead** **Frequency:** Once **Priority:** STAT **Maximum Quantity:** 6 **Comments:** To be performed by ED Staff - Show immediately to ED MD
Question(s):
Clinical Indications: ○ Other:
Other: Per ACS Protocol
Interpreting Physician:

Imaging

Diagnostics X-Ray

☐ **Abdomen Acute Inc Chest** **Frequency:** 1 time imaging **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Abdomen Ap And Lateral** **Frequency:** 1 time imaging **Priority:** STAT **Comments:** Flat
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Abdomen 1 Vw Portable** **Frequency:** 1 time imaging **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Diagnostics CT

☐ **CT Abdomen and Pelvis with IV and PO Contrast (Omnipaque)**
For those with iodine allergies, please order the panel with Readi-Cat (barium sulfate).

☑ **CT Abdomen Pelvis W Contrast** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Is the patient pregnant?
Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☑ **iohexoL (OMNIPAQUE) 350 mg iodine/mL injection** **Dose:** 100 mL **Route:** intravenous **Frequency:** once in imaging **Priority:** STAT
Question(s):
Indication(s) for Once Reason:

☑ **sodium chloride 0.9 % bolus** **Dose:** 50 mL **Route:** intravenous **Frequency:** once in imaging **Priority:** STAT **Minimum Infusion Duration:** 1.000 Minutes **PRN Comment:** Flushes
Question(s):
Indication(s) for Once Reason:

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** **Dose:** 30 mL **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Readi-Cat)**
Ordered as secondary option for those with iodine allergies.

☑ **CT Abdomen Pelvis Wo Contrast** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☐ **barium (READI-CAT 2) 2.1 % (w/v), 2.0 % (w/w) suspension** **Dose:** 2 **Route:** oral **Frequency:** once in imaging **Priority:** STAT

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Omnipaque)**
For those with iodine allergies, please order the panel with Readi-Cat (barium sulfate).

☑ **CT Abdomen Pelvis Wo Contrast** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☐ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** **Dose:** 30 mL **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Renal Stone Protocol** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Diagnostic US

☐ **US Abdomen Complete** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
NPO 8 hours before exam.

Sign:_____ **Printed Name:**_____
Date/Time:_____

☐ **US Abdomen Limited** **Frequency:** 1 time imaging **Priority:** STAT **Comments:** Right Upper Quadrant
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
NPO 8 hours before exam.

☐ **US Gallbladder** **Frequency:** 1 time imaging **Priority:** STAT
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
NPO 8 hours before exam.

☐ **US Scrotal** **Frequency:** 1 time imaging **Priority:** STAT
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **US Pelvic Non Ob Limited** **Frequency:** 1 time imaging **Priority:** STAT
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

Ultrasound & Misc

☐ **US Pregnancy Single Greater Than 14 weeks with US Pregnancy Transvaginal**

☑ **US Pregnancy Single Less Than 14 Weeks** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

☑ **US Pregnancy Transvaginal** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

☐ **US Pregnancy Single Greater Than 14 weeks with US Pregnancy Transvaginal**

☑ **US Pregnancy Single Less Than 14 Weeks** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

☑ **US Pregnancy Transvaginal** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

☐ **US Pregnancy Greater Than 14 weeks - Limited** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

☐ **US Pregnancy Greater Than 14 weeks - Limited** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

Other Studies
Respiratory
Rehab

Sign:_____ **Printed Name:**_____
Date/Time:_____

Consults

For Physician Consult orders use sidebar

Additional Orders

Sign:_____ **Printed Name:**_____

Date/Time:_____