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_____ Fentanyl_____ Total Intake _____
Other _____ Nitro _____ Versed_____ Total Output _____
Antibiotics _____ Blood _____ Heparin _____
Contrast _____

	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)

NURSING INTERVENTIONAL RADIOLOGY DOWNTIME 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   Character: ☐ stabbing ☐ Burning ☐ sharp

          ☐ Intermittent   ☐ Other   ☐ 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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|||||| BARCODE ||||||
1000000

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