HUC - CLASS ASSIGNMENT #2

Diagnosis: Lt hip fx

Comorbidities: ☐ Angina ☐ Atrial Fibrillation ☐ Cardiomyopathy ☒ COPD ☐ CHF ☐ Dehydration ☐ Malnutrition ☐ Diabetes with manifestations ☐ Diabetes, Insulin Dependent ☐ Diabetes, Uncontrolled ☐ Other: _____

Consults:

☒ Notify Primary Care Physician of admission Dr John Faulkner DO

Treatments:

☒ Indwelling urinary catheter for hip fracture

Activity:

☒ Bedrest with 5# Bucks Traction for hip fracture.

Diet:

☐ Nothing by mouth

☒ Other: mech soft

Diagnostics:

☒ Chest x-ray: Reason: pre-op

☒ Arterial Blood Gases

☒ Electrocardiogram: Reason: pre-op

Laboratory Requests:

☒ Complete Blood Count

☒ Partial Thromboplastin Time, Prothrombin Time

☒ Sodium, Potassium, Creatinine

☒ Urine reflex (reflex to culture if leukocyte or nitrite positive, also if moderate to many microorganisms found).

☒ Type & Screen.

Medications: **Hold and Notify Physician of any Allergies to Ordered Medication.**

☒ 1000 mL Dextrose 5% and 0.9% Sodium Chloride IV. Run at 75 mL/hour continuously.

☒ Add 20 mEq potassium chloride to each liter of IV fluids

☐ Other: _____

☒ Cefazolin Sodium (Ancef):1 gm IV piggyback: **Send with patient to Surgery**. Give every 8 hours for a total of 3 doses post op.

☐ Clindamycin 600 mg IV piggyback. Send with patient to Surgery. Give every 12 hours for 2 doses post op.

☒ **Notify physician if allergic to cephalosporins or penicillin**

☐ Other: _____

☒ Ondansetron (Zofran) 4 mg slow IV push over 2 minutes **one time dose** for post op nausea. **Day of surgery only**

☒ Prochlorperazine (Compazine) 5 mg slow IV push over 2 minutes every 6 hours as needed for nausea. May give orally **Total Maximum dose in 24 hours is 40 mg.**

☐ Other: Advair 250/50 1 puff am + pm
Singulair 10mg 1 q day

Physician Name—Print and Sign—To Activate Only Orders Checked Above	Date	Time
Dr Thomas Hughes MD	X/XX/XX	0930

PATIENT IDENTIFICATION

Opportunity Medical Center
1912 Lake Pleasant Dr.
Pleasantville, Anystate 19480

Medications Continued

Medications: **Hold and Notify Physician of any allergies to Ordered Medication.**

Pain Medications:

☒ Morphine Sulfate 2-10 mg to be given intravenously or intramuscular every 4 hours as needed for pain:
Mild Pain (pain = 1-4) = 2 mg.
Moderate Pain (pain = 5-7) = 4 mg.
Severe Pain (pain = 8) = 8 mg.
Severe Pain (pain = 9-10) = 10 mg.

☒ ***If allergic to Morphine, give Meperidine and Hydroxyzine as indicated below, and discontinue Morphine.***
☒ Meperidine (Demerol) 25-100 mg given with Hydroxyzine (Vistaril) 25 mg **intramuscularly** every 4 hours as needed for pain:
Mild Pain (pain = 1-4) = 25 mg Meperidine with 25 mg Hydroxyzine.
Moderate Pain (pain = 5-7) = 50 mg Meperidine with 25 mg Hydroxyzine.
Severe Pain (pain = 8) = 75 mg Meperidine with 25 mg Hydroxyzine.
Severe Pain (pain = 9-10) = 100 mg Meperidine with 25 mg Hydroxyzine.

Choose ONLY ONE of the following narcotic and acetaminophen combination agents for moderate and severe pain management:

☐ Oxycodone/Acetaminophen (Percocet) 5 mg/325 mg 1-2 tablets to be given orally every 4 hours as needed for pain:
Moderate Pain (pain = 5-7) = 1 tablet.
Severe Pain (pain = 8-10) = 2 tablets.

☐ Propoxyphene/Acetaminophen (Darvocet-N 100) 100 mg/650 mg 1-2 tablets to be given orally every 4 hours as needed for pain
Moderate Pain (pain = 5-7) = 1 tablet.
Severe Pain (pain = 8-10) = 2 tablets.

☒ Acetaminophen (325 mg): Give two tablets orally every four hours as needed for mild pain (pain = 1-4) or fever > 101 degrees.
☐ Other: _____

Total Acetaminophen not to exceed 4 grams per day.

Additional Orders: D/W/C VO albuterol TID
ABG on RA & call results
Dr Shalini Taylor MD

On 2L per NP cont.
Dr Shalini Taylor MD

Physician Name — Print and Sign — To Activate Only Orders Checked Above: Dr Shalini Taylor MD | Date: 1/XX/XX | Time: 1020

PATIENT IDENTIFICATION

Opportunity Medical Center
1912 Lake Pleasant Dr.
Pleasantville, Anystate 19480

Patient Care Plan
Surgery/Post Acute Surgery

Advance Care Plan Level: Review Date:		Health Care Directive ☐ Yes ☐ No	**Contact person**	**Relationship**	**Phone no.**
PRN Pass	Pacemaker ☐ Yes ☐ No	Age:	1)		
Allergies:			2)		
Diagnosis:			**Consult**		
			Service	**Notified**	**Seen**
Surgery:					
Adm Date:	OR Date:	Post-Op Day:			
Pain Protocol: Stop epidural if systolic BP is less than _____ mmHg HS sedation:					

Venous Access	**Relevant Information/Past Medical History**
Intravenous Solution: Site: Tubing Change Due: **Port-a-Cath/PICC/Central line:** _____ Flush with: Due: Dressing change due: Cap change due:	
Oxygen: Home Oxygen:	Diet: Accuchecks:

Miscellaneous Medical Orders	**Dressings/Sutures/Staples/Packing**
☐ TEDS ☐ SCD ☐ Heel Boot ☐ Gel Pad ☐ Knee Map ☐ Hip Map ☐ CPM ☐ Abd/Reg Pillow	Site: Change due: Staples/Sutures: ☐ In ☐ Out Remove:

Ostomy Teaching	**Ortho Teaching**
POD1 Purpose and Type of Stoma	OR Day DB&C, Hydration, Pain Control
POD2 Acceptance of Stoma	POD1-2 Mobility Precautions
POD3 Clamp Use	POD3 Fragmin Handout & Kit and
POD4 Empty Appliance	"What You Need to Know For Home" handout
POD5 Change Appliance	POD4 Review S/S infection, DVT, PE and Edema
POD6 Resources after Discharge	POD5 Return Demonstration of Fragmin Injection

Output			**Assessments/Frequency**	**Risk Management**
Measure at: 0700, 1500, and 2300 hours			☐ Neurological	☐ Falls Prevention
☐ NG Tube	☐ Foley Cath	☐ Colostomy	☐ Neurovascular	☐ Side Rails x ___
☐ Hemovac	☐ Kelly Irrigation	☐ ileostomy	☐ Respiratory	☐ Call Bell
☐ JP Drain	☐ Suprapubic Cath	☐ ileoconduit/Urostomy	☐ G.I.	☐ Constant Care
☐ Penrose	☐ Ureteral Cath	☐ Nephrostomy	☐ Vitals – pain protocol	☐
☐	☐	☐	☐ Vitals – Tues, Thurs, Sat	☐

Discard after patient's discharge.

Ambulation

- ❑ Independent
- ❑ Stand By Assist
- ❑ 1 Assist
- ❑ 2 Assist
- ❑ NWB ❑ Feather WB ❑ Partial WB ❑ Full WB
- ❑ Walker ❑ Cane ❑ Crutches
- ❑ Transfer Belt ❑ Other

Transfer

- ❑ Bedrest ❑ Logroll ❑ Buck's Traction
- ❑ Medi-Man ❑ Sara Lift ❑ Imex Chair
- ❑ Raised Chair ❑ Reclining W/C ❑ Standard W/C
- ❑ Amputation: ❑ Prosthesis
- ❑ Turn and Position q2h ❑ Other

Elimination

- ❑ Bathroom ❑ Urinal ❑ Bedpan
- ❑ Commode ❑ Foley ❑ Brief/Liner
- ❑ Incontinent Bowel ❑ Incontinent Bladder
- ❑ BM q3 days Last BM:
- ❑ Colostomy ❑ ileostomy ❑ Urostomy
- ❑ Bag Change Date:

Hygiene

- ❑ Self ❑ Assist ❑ Complete ❑ Set up
- ❑ Basin ❑ Sink ❑ Bed ❑ Shower ❑ Sitz Bath
- ❑ Oral Care am / hs ❑ Peri Care am / hs
- ❑ Hearing Aides ❑ Right ❑ Left ❑ Glasses
- ❑ Dentures ❑ Upper ❑ Lower

Nutrition

- ❑ Self ❑ Assist ❑ Complete ❑ Set up ❑ Supervise
- ❑ Encourage Fluids
- ❑ Restrict Fluids Day_____mL
  Evening _____mL
  Night_____mL

Tube Feed: Flush:

Calorie Count:

TPN: Solution/Rate:
Solution/Rate:
Frequency of Weights:

Referrals

Service	Date Sent	Date Answered	Service	Date Sent	Date Answered
Physiotherapy			Pharmacy		
Occupational Therapy			Dietician		
Home Care			Ostomy Nurse		
Social Work			Infection Control		
Wound Care			Respiratory		
Psych Liaison					

Laboratory Tests	Date to be done	Diagnostic Tests	Date to be done

Specimen Collection [Specimen]	Date to be Done	Group & Match No. of Units:	Expiry date	❑ Donated ❑ Autologus
		#1 given:		
		#2 given:		
		#3 given:		
		#4 given:		

Discharge Plans — **Anticipated Discharge Date:**

CONSENT TO OPERATION OR PROCEDURE

I, _____, hereby consent to undergo the operation or procedure of
(Patient's Full Name)

_____

_____ to be performed

or directed by Dr. _____.
(Physician or Surgeon)

The nature, purpose and effects of this operation or procedure, as well as the attendant risks and alternatives, have been clearly and adequately explained to me by Dr. _____.
(Physician or Surgeon)

I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

I consent to such further extended or alternative operative measures as may be found necessary or advisable in my interest during the course of the above operation or procedure.

I consent to the administration of anaesthetics, drugs, blood, blood products, and monitoring devices considered necessary or advisable by the doctors in whose care I hereby place myself.

I consent to the assistance of other Hospital medical staff at the physician's discretion.

I agree to the disposal, by the Hospital, of any tissues or parts surgically removed.

I also hereby consent to the disclosure of information necessary to support claims for insurance and hospitalization benefits. I also agree that health records may be used for Continuous Improvement activities.

I CERTIFY THAT I HAVE READ/HAVE HAD READ/HAVE HAD INTERPRETED, AND FULLY UNDERSTAND THE ABOVE CONSENT FOR OPERATION OR PROCEDURE.

_____
Witness to Signature of Patient or Person Providing Consent

_____
Signature of Patient or Person Providing Consent

_____
Date of Consent

_____
Time of Consent

_____
Witness to Patient's mark (X) or Telephone Consent

_____

_____
Witness to Patient's mark (X) or Telephone Consent

_____
Address of Witness if not Hospital Employee

_____
interpreter (if applicable)

If signed by a person other than the patient, complete the following:

The reason I am signing for the patient is: _____

_____

I provide this consent in my capacity of: Parent ☐ Spouse ☐ Next-of-kin ☐
Guardian ☐ Other ☐ _____

CONSENT TO NON-USE OF BLOOD

I, _____, request that no blood or blood products be administered to me
(Patient's Full Name)
during this hospitalization, notwithstanding that such treatment may be deemed necessary in the opinion of the attending medical practitioner or the Hospital staff to preserve life or promote recovery.

I release the Hospital and its staff and all physicians in any way connected with my treatment from any responsibility, whatsoever, for any untoward results due to my refusal to permit the use of blood or its derivatives.

_____ _____
Witness to Signature of Patient or Person Providing Consent | Signature of Patient or Person Providing Consent

_____
Date of Consent | Time of Consent

_____ _____
Interpreter (if applicable)

_____
Address of Witness if not Hospital Employee

If signed by a person other than the patient, complete the following:

The reason I am signing for the patient is: _____

I provide this consent in my capacity of: Parent ☐ Spouse ☐ Next-of-kin ☐
Guardian ☐ Other ☐ _____

ROBERTSON GENERAL HOSPITAL

SCHEDULED MEDICATIONS

ALLERGIES: ______________________

ORDER DATE	REORDER DATE	START DATE	STOP DATE	SCHEDULE	MEDICATION/DOSE/ROUTE	YEAR					
			RN			DATE	DATE	DATE	DATE	DATE	DATE
						TIME INIT.	TIME INIT.	TIME INIT.	TIME INIT.	TIME INIT.	TIME INIT.

ROBERTSON GENERAL HOSPITAL

NON-SCHEDULED MEDICATIONS

ALLERGIES: ______________________

NONRECURRNG MEDICATION	RN	DATE TIME	START DATE RN	STOP DATE RN	PRN MEDICATIONS	YEAR DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.

STATS and NON-RECURRING MEDICATIONS
MEDICATION ADMINISTRATION RECORD (MAR)

Wt _____ Refer to: ☐ Diabetic Flowsheet
☐ ICU Flowsheet
☐ Epidural Flowsheet
☐ PCA Flowsheet

DATE

PATIENT

DOB

PROV HC#

DOCTOR

CLINIC/UNIT LOC'N

ALLERGIES:

MEDICATION ORDERED YEAR 20____							MEDICATION GIVEN	
DATE DD/MONTH / TIME	MEDICATION NAME	DOSE	ROUTE	INSTRUCTIONS	INITIALS TRAN-SCRIBER	INITIALS NURSE	DATE (IF DIFFERENT) / TIME	INITIALS GIVEN BY / 2ND IF NEEDED

STATS and NON-RECURRING MEDICATIONS
MEDICATION ADMINISTRATION RECORD (MAR)

Wt _____ Refer to: ☐ Diabetic Flowsheet
☐ ICU Flowsheet
☐ Epidural Flowsheet
☐ PCA Flowsheet

DATE

PATIENT

DOB

PROV HC#

DOCTOR

CLINIC/UNIT LOC'N

ALLERGIES:

MEDICATION ORDERED **YEAR 20 ____**

MEDICATION GIVEN

DATE DD/MONTH / TIME	MEDICATION NAME	DOSE	ROUTE	INSTRUCTIONS	INITIALS TRAN-SCRIBER	INITIALS NURSE	DATE (IF DIFFERENT) / TIME	INITIALS GIVEN BY / 2ND IF NEEDED

*** PLEASE COMPLETE THE INFORMATION BELOW, PRINT CLEARLY ***

NAME OF PHYSICIAN ORDERING TEST: ..... (LAST) ..... (FIRST)

REFERRING INSTITUTION NAME AND ADDRESS OR CODE:

IF AN ADDITIONAL REPORT IS REQUIRED, PLEASE COMPLETE THE FOLLOWING:

PHYSICIAN NAME: .....

ADDRESS: .....

CITY: ..... PROV. ..... POSTAL CODE .....

TELEPHONE NO. ..... FAX NO. .....

ENCOUNTER NO.: ..... LOCATION (WARD/CLINIC): .....

PATIENT NAME: ..... (LAST) ..... (FIRST)

DATE OF BIRTH: ..... DD/MM/YYYY SEX: ☐ F ☐ M

FACILITY PATIENT ID NO.: .....

PHIN (if applicable): .....

PHYSICIAN/PHYSICIAN NO.: .....

COLLECTION DATE: .....

COLLECTION TIME: .....

COLLECTED BY: .....

SPECIMEN ID # HSC LAB USE ONLY

SCHEDULED COLLECTION: DATE: _____ TIME: ☐ 0800 ☐ OTHER: _____

COLLECTED BY: ☐ VENIPUNCTURE ☐ INDWELLING LINE ☐ ABOVE SHUT-OFF IV

	CHEMISTRY	
	Sodium	NA
	Potassium	K
	Chloride	CL
	Total CO_2 (Bicarbonate)	CO2
	Glucose	G
	Urea	U
	Creatinine	CR
	Calcium	CA
	Phosphate	P
	Magnesium	MG
	CK	CK
	Troponin T	TNT
	Myoglobin	SMYO
	Total Protein	TP
	Albumin	AL
	Lipoprotein Profile (Includes CH, TG, HDL, LDL)	LIPP
	Cholesterol	CH
	Triglyceride	TG

	CHEMISTRY	
	Alkaline Phosphatase	ALK
	ALT (SGPT)	ALT
	AST (SGOT)	AST
	Bilirubin, Total	TB
	Bilirubin, Direct	DB
	γ-Glutamyl Transferase	GGT
	LD	LD
	Lipase	LIP
	Uric Acid	UA
	Iron	IRON
	TIBC	TIBC
	Osmolality	OS
	Alpha-Fetoprotein	AFP
	Beta-2 Microglobulin	B2M
	CA125	CA1
	CA 15-3	CA15
	CA 19-9	CA19
	Carcinoembryonic Antigen	CEA
	PSA	PRSA

	CHEMISTRY		
	Ammonia	Send on ice	AMM
	Angiotensin Conv. Enz.		ACE
	Beta-Hydroxybutyrate		BHB
	Ceruloplasmin		CERU
	Ethanol		ETO
	FEP		FEP
	Ferritin		FER
	Glycated Hemoglobin		GYHB
	Haptoglobin		HPT
	Homocysteine	Send on ice	HCQ
	IgE		IGE
	Ionized Calcium		ICA
	Lactic Acid	Send on ice	LAC
	Lead		PB
	Prealbumin		PALB
	PTH	Send on ice	PTH
	Vitamin B12		B12
	Vitamin D25		D25
	Zinc		ZN

	ENDOCRINE TESTS		
	ACTH	Send on ice	ACTH
	Cortisol		COR
	DHAS		DHAS
	Estradiol		E2
	FSH		FSH
	Growth Hormone		GH
	HCG (Quantitative)		HCGQ
	17-Hydroxyprogesterone		PR17
	Insulin		INS
	LH		LH
	Progesterone		PGN
	Prolactin		PL
	SHBG		SHBG
	Testosterone		TST
	FAI		FAI
	T3, Free		FT3
	T4, Free		FT4
	TSH		TSH
	Thyroperoxidase Antibodies		TPO

	HEMATOPATHOLOGY	
	Complete Blood Count (includes 5 cell differential)	CBC
	Blood Film Review (**Reason must be given**) Reason:	SLR
	Reticulocyte Count	RETA
	Sedimentation Rate (ESR)	ESR
	Sickle Cell Screen	HSS
	Malaria	MAL
	Cold Agglutinin Screen	HCA
	Glucose-6-Phosphate Dehydrogenase	GPD
	PT/INR/Pfib	PT
	APTT	APTT
	Fibrinogen	CFIB
	D-Dimer (Qualitative)	DDIM
	Lupus Inhibitor	LUPS
	Factor V Leiden	MOL
	Prothrombin Variation (G20210A)	MOL
	Heinz Body Screen	HBA

	DRUG LEVELS			
	Acetaminophen	ACTM		Mycophenolic Acid	MPA
	Amiodarone	AMIO		Phenobarbital	PHEN
	Carbamazepine	CARB		Phenytoin	PYN
	Cyclosporin	CY		Salicylate	SAL
	Digoxin	DIG		Sirolimus	SIRO
	FK506	FK5		Theophylline	TEO
	Gentamicin	GENT		Tobramycin	TOBR
	Lithium	LI		Valproic Acid	VALP
	Methotrexate	MTX		Vancomycin	VANC

LAST DOSE: TIME: DATE: (D/M/Y)

NEXT DOSE: TIME: DATE: (D/M/Y)

IV FINISH: TIME:

OTHER TESTS (Please Print)

SPECIMEN COLLECTION INSTRUCTIONS

Tests marked in red require special collection and/or transport. Consult the Lab Information Manual or call the laboratory.

CLINICAL INFORMATION

URGENT

CHEMISTRY/HEMATOPATHOLOGY TEST REQUISITION

LABORATORY TEST REQUEST BLOOD, SERUM OR PLASMA

Electrocardiograph [EKG] Requisition

Date_____ Time of Page _____ EKG no. _____

Record to be taken: ☐ on nursing unit ☐ in Lab ☐ Routine ☐ Emergency ☐ Stat

☐ Chest Pain ☐ Pulmonary Disease ☐ Other _____
☐ Palpitations ☐ Routine Pre-op
☐ Arrhythmia ☐ Repeat

Current Medications

Other Relevant Information

Ordering Physician

REPORT

☐ **Normal EKG**
☐ **Abnormal EKG**
☐ **Borderline EKG**

Ventricular Rate	Atrial Rate	Pr Interval [sec]	QRS Interval [sec]	QTC Interval [sec]	+ / -	Frontal Axis [degrees]
		0.	0.	0.		

Wave Form Abnormalities
QRS Avis Deviation [Dev]
☐ Right Dev ☐ Ant Dev
☐ Left De. ☐ Post Dev

P. Waves
☐ Right Atrial Abnormal
☐ Left Atrial Abnormal
☐ Ectopic
☐ Retrograde

Pr Interval	Qt interval
☐ Long	☐ Long
☐ Short	☐ Short

QRS
☐ Low voltage
☐ High voltage
☐ Dec anterolat forces
☐ Pathology Q waves

ST Seg
☐ Prominent Vector

T Waves
☐ Abnormal Axis
☐ High voltage
☐ Low voltage

Interpretation

Change since Previous EKG
☐ Yes
☐ No

Ventricular Hypertrophy
☐ Right
☐ Left
☐ Combined

ST and/or T Wave Abnormal [non-specific]

Pacemaker Function
☐ Normal
☐ Non-capturing
☐ Non-sensing
☐ Other

☐ **Metabolic Disturbance**
☐ **Pericardial Disease**

Myocardial Infarction
☐ Yes
☐ Possible
☐ Could be ischemia

Time
☐ Recent
☐ Evolving
☐ Old
☐ Recent and Old
☐ Could be either

Extension Recent Infarction
☐ Yes
☐ Possible

Site
☐ Anterior
☐ Anteroseptal
☐ Inferior
☐ True Posterior
☐ Lateral
☐ Other [specify]

Rhythm

Sinus
☐ Rhythm
☐ Bradycardia
☐ Arrest
☐ Tachycardia

Atrial
☐ Ectopic Beats
☐ Tachycardia
☐ Fibrillation
☐ Flutter

Junctional
☐ Ectopic Beats
☐ Tachycardia
☐ Rhythm

Ventric
☐ Ectopic Beats
☐ Tachycardia
☐ Rhythm
☐ Fibrillation

☐ Reciprocal Beats / Rhythm

Conduction

☐ **First Degree Block**
☐ **Second Degree Block**
☐ Type 1
☐ Type 2
☐ 2:1
☐ **Third Degree Block**
☐ **Right Bundle Block**
☐ Complete
☐ Incomplete
☐ **Left Bundle Block**
☐ Complete
☐ Incomplete
☐ **Left Anterior HB**
☐ **Left Posterior HB**
☐ **Pre-Excitation**
☐ **Indeterminate Conduction Disturbance**
☐ **Intermittent Normal Conduction**
☐ **Sinus Atrial Block**
☐ **Sinus Arrest**
☐ **AV Dissociation**

Legend
+ / - means positive/negative; ant means anterior; post means posterior; Dec means descending; HB means hemi block; AV means atrial ventricular node

Comments

Signature of EKG Technologist	Date	Time of Tracing	Signature of Reporting Physician

White – Health Record Copy **Yellow – File Copy** **Pink – Billing Copy**

BLOOD GAS & ACID-BASE REPORT
RESPIRATORY LAB

DATE:

WARD:

FULL NAME:

YEAR OF BIRTH:

HOSPITAL #:

PHYSICIAN:

DIAGNOSIS:	
	[ ] ARTERIAL [ ] ROOM AIR [ ] CAPILLARY [ ] OXYGEN _____ L/min. [ ] SCALP _____ % [ ] CORDS [ ] DEVICE _____ [ ] VENOUS

	PO_2 mmHg	
	PCO_2 mmHg	
	pH	
	HCO_3 mmol/L [ ] Std. [ ] Calc.	
	B.E. / B.D. mmol/L	
	O_2 SAT [ ] Meas'd [ ] Calc.	
	O_2 CONTENT g/L	
	HEMOGLOBIN (Hb g/dl)	
	CARBOXYHEMOGLOBIN (HbCO%)	
	METHEMOGLOBIN (MetHb%)	
	P5O	

SIGNATURE:

DATE:	TIME TAKEN
	TIME ANALYZED

FORM 70850 (4/10)

PRINTED IN CANADA

ACID-BASE REPORT RESPIRATORY LAB

BLOOD GAS & ACID-BASE REPORT
RESPIRATORY LAB

DATE:

WARD:

FULL NAME:

YEAR OF BIRTH:

HOSPITAL #:

PHYSICIAN:

DIAGNOSIS:

[ ] ARTERIAL [ ] ROOM AIR
[ ] CAPILLARY [ ] OXYGEN _____ L/min.
[ ] SCALP _____ %
[ ] CORDS [ ] DEVICE _____
[ ] VENOUS

PO_2 mmHg
PCO_2 mmHg
pH
HCO_3 mmol/L [ ] Std. [ ] Calc.
B.E. / B.D. mmol/L
O_2 SAT [ ] Meas'd [ ] Calc.
O_2 CONTENT g/L
HEMOGLOBIN (Hb g/dl)
CARBOXYHEMOGLOBIN (HbCO%)
METHEMOGLOBIN (MetHb%)
P5O

SIGNATURE:

DATE:
TIME TAKEN
TIME ANALYZED

FORM 70850 (4/10)

PRINTED IN CANADA

ACID-BASE REPORT RESPIRATORY LAB

REQUEST FOR CONSULTATION FOR DIAGNOSTIC IMAGING EXAM

DATE

PATIENT

DOB

PROV HC#

DOCTOR

CLINIC/UNIT LOC'N

☐ **Outpatient**
☐ First Available Site Fax to Access Centre 787-8910
or
☐ Preferred Site(s) _____ (see reverse)

☐ ER
☐ Inpatient _____ (Site and Unit)

Date Exam Needed: _____ ACP #: _____

PATIENT INFORMATION

PHIN _____ **Sex** ☐ Male ☐ Female
Other Insurance No. _____ **WCB #** _____
Address _____
City _____ **Province** _____ **Postal Code** _____
Phone Home ( ) _____ **Work** ( ) _____ **Cell** ( ) _____
Emergency Contact/Next of Kin _____ **Maiden Name** _____

HISTORY AND EXAMINATION REQUESTED

(See WRHA website for additional information and forms for Breast U/S; PET; Mammography, Bone Density)

Modality Requested (select one)
☐ X-Ray ☐ Ultrasound ☐ CT ☐ Nuclear Medicine ☐ MRI

Examination Requested

☐ Elective
☐ Urgent

*Note: For ***emergent*** outpatient exams, Radiologist must be contacted directly

METHOD OF TRANSPORT

☐ Wheelchair ☐ Stretcher ☐ Ambulatory ☐ Portable
☐ Gerichair ☐ Bed ☐ Will Require Lift

Previous Relevant Exams Date Location

1. _____
2. _____
3. _____

History and Provisional Diagnosis. Patient on Infection Control Precautions? Specify

MUST COMPLETE FOR ALL EXAMS

Patient Weight _____
Patient Height _____
Is patient pregnant? ☐ Yes ☐ No
LNMP ____ / ____ / ____ (dd / mm / yy)
Is patient nursing? ☐ Yes ☐ No

For invasive procedures:
INR (within 24 hours of exam) _____
Platelets (within 24 hours of exam) _____

FOR CONTRAST ENHANCED EXAMS

If contrast media is required, no solid food 4 hours prior to study. Normal fluid intake. If the patient is diabetic, please adjust medication accordingly.

"Allergy" to X-Ray dye ☐ Yes ☐ No

Contrast media can reduce renal function in patients with the following risk factors: *(check all that apply)*

☐ Kidney Disease ☐ Collagen Vascular Disease ☐ Receiving Metformin, Interleukin, NSAIDs
☐ Diabetes ☐ Myeloma ☐ Age > 65 years

For these "at risk" patients:
- provide Serum Creatinine (within 90 days of exam or 30 days if known renal disease) _____
- consider stopping NSAIDs, ACE inhibitors or other nephrotoxic medications prior to the procedures.
- stop Metformin 48 hours following IV contrast injection and check renal function prior to re-initiating medication.

MUST COMPLETE FOR ALL MRI EXAMS

Cardiac Pacemaker ☐ Yes ☐ No **If yes, patient cannot be scanned.**

For contrast enhanced exams:
☐ Patient on hemodialysis
☐ Patient on peritoneal dialysis
☐ Serum Creatine > 250 umol/L or GFR < 30 mL/min

PEDIATRIC MRI PATIENTS ONLY:
Gastroesophageal Reflux ☐ Yes ☐ No
Sleep Apnea ☐ Yes ☐ No
Abnormal Airway ☐ Yes ☐ No
Chronic Chest Infections ☐ Yes ☐ No
Neuromuscular Problems ☐ Yes ☐ No
Pediatric Head Circumference _____

Check conditions that apply:
☐ Heart Valve
☐ Aneurysm surgery or aneurysm clips. If yes, forward OR report prior to MRI exam.
☐ Implanted Devices; i.e. stimulators, shunts, electrodes, pumps, Strata vaives, inner ear implants etc.
☐ Claustrophobic, and/or other medical condition that requires sedation.
☐ Metal in eyes or previous eye surgery. If yes, forward orbit x-ray report prior to exam.
☐ Patient cannot lie supine for 30 minutes.

AUTHORIZED CLINICIAN INFORMATION

Signature (Print and Sign) _____ MHSC Billing # _____

Address _____ Phone # _____ Fax # _____ Date _____

Extra Report To: _____ Fax # _____
Name/Address/Phone

Office Use Only Coding

Appointment Date/Time

CONTACT LIST

Fax and Contact Phone Numbers

	Fax #	Phone #
DI Access Centre (For First Available Appointment)	**787-8910**	787-8907
Breast Health Centre	**231-3839**	235-3626
Concordia Hospital		
CT/Ultrasound	**661-7329**	661-7436
Fluoroscopy	**661-7329**	661-7436
X-Ray	**654-3884**	661-7212
Deer Lodge Centre	**832-0619**	831-2158
Grace Hospital		
CT/Ultrasound	**837-0586**	837-0171
Nuclear Medicine	**837-0586**	837-0179
X-Ray/Fluoroscopy	**837-0586**	837-0806
Health Sciences Centre		
Angiography	**787-3193**	787-7620
CT	**787-7295**	787-3053
Fluoroscopy	**787-7482**	787-4630
Mammography	**787-3558**	787-5050
MRI	**787-3118**	787-1323
Nuclear Medicine	**787-3090**	787-3375
PET	**787-3300**	787-3122
Ultrasound	**787-3355**	787-3076
X-Ray	**787-3558**	787-3241
Health Sciences Centre - Child Health		
Pediatric CT	**787-4808**	787-4800
Pediatric Nuclear Med	**787-3090**	787-3375
Pediatric US	**787-4808**	787-4800
Pediatric X-Ray/Fluoroscopy	**787-1439**	787-2288

	Fax #	Contac
Misericordia Health Centre		
CT	**772-6748**	788-8264
Ultrasound	**772-6748**	788-8267
X-Ray/Fluoroscopy	**772-6748**	788-8266
Pan Am (MRI)	**927-2686**	927-2674
Riverview Health Centre	**478-6273**	478-6123
St. Boniface General Hospital		
Angiography	**237-7439**	237-2526
CT	**233-6377**	235-3150
Mammography	**237-7439**	237-2526
MRI	**233-2777**	235-3600
Nuclear Medicine	**237-2007**	237-2748
Ultrasound	**231-0355**	237-2531
X-Ray/Fluoroscopy	**237-7439**	237-2526
Seven Oaks General Hospital		
CT	**694-9323**	632-31
Nuclear Medicine	**694-9323**	632-32
Ultrasound/Fluoroscopy/X-Ray	**694-9323**	632-3526
Victoria General Hospital		
CT/Fluoroscopy/X-Ray	**269-7723**	477-3179
Nuclear Medicine	**269-7723**	477-3175
Ultrasound	**269-7723**	477-3132

WRHA Webpage for Diagnostic Imaging Requisition Forms:

www.wrha.mb.ca/prog/diagnostic/forms.php

*** PLEASE COMPLETE THE INFORMATION BELOW, PRINT CLEARLY ***

NAME OF PHYSICIAN ORDERING TEST: ..... (LAST) ..... (FIRST)

REFERRING INSTITUTION NAME AND ADDRESS OR CODE:

IF AN ADDITIONAL REPORT IS REQUIRED, PLEASE COMPLETE THE FOLLOWING:

PHYSICIAN NAME: .....

ADDRESS: .....

CITY: ..... PROV. ..... POSTAL CODE .....

TELEPHONE NO. ..... FAX NO. .....

ENCOUNTER NO.: ..... LOCATION (WARD/CLINIC): .....

PATIENT NAME: ..... (LAST) ..... (FIRST)

DATE OF BIRTH: ..... (DD/MMM/YYYY) SEX: ☐ F ☐ M

FACILITY PATIENT ID NO.: .....

PHIN (9 DIGITS): .....

PHYSICIAN/PHYSICIAN NO.: .....

COLLECTION DATE: .....

COLLECTION TIME: .....

COLLECTED BY: .....

DPS CAMPUS ID & HSC LAB USE ONLY

TIMED COLLECTIONS: START DATE/TIME: _____ STOP DATE/TIME: _____

VOLUME: _____ mL

	URINE			CSF	
	Sodium	NAU		Cell Count & Differential	CSFH
	Potassium	KU		Chloride	CLC
	Creatinine	CRU		Glucose	GLC
	Osmolality	OSU		Protein, Total	PC
	Albumin	UALB			
	Calcium	* CAU		**FLUIDS**	
	Chloride	CLU		Type _____	
	Citrate	* CITU		Cell Count & Differential	HFLD
	Cortisol	* CORU		Crystals	CRYS
	Creatinine Clearance	CRCL		Fetal Lung Maturity	LP
	Ht. _____ cm Wt. _____ kg			Fluid for Eosinophils	FFE
	Homovanillic Acid	* HVA		Albumin	ALFL
	Hydroxyindole Acetic Acid	* HIAA		Bilirubin, Total	BFL
	Metanephrines	* MNPH		Chloride	CLFL
	Oxalate	* OXU		Creatinine	CRFL
	Phosphate	POU		Glucose	GFL
	Porphobilinogen	* PBG		LD	LDFL
	Porphyrins	* POR		Lipase	LPFL
	Pregnancy Test	PREG		Potassium	KFL
	Protein, Total	TPU		Protein, Total	TPFL
	Urea	UU		Sodium	NAFL
	Uric Acid	UAU		Urea	UFL
	Urobilinogen	* UBGQ		Uric Acid	UAFL
	Vanillymandelic Acid	* VMA		**STOOL**	
				Fat (Quantitative)	* FF
	Urinalysis (Dipstick)	UR		Natural & Split Fats	FECA
	Urine Microscopic Review **Reason must be given** Reason:	RFM		Occult Blood	OB
				pH	* PHF
				Reducing Substances	* RSF
				Stool for Leukocytes	SFL

SPECIAL INVESTIGATIONS

(Appropriate clinical data must be completed)

Metabolic Screen	1 mL blood (fasting)	Plasma	AAQP
	plus 20 mL urine	Urine	METU

Time blood drawn _____

Time of last feed _____

History _____

Clinical/Lab Findings _____

Other Information _____

SPECIMEN COLLECTION INSTRUCTIONS

Tests marked in * require special collection and/or transport. Consult the Lab Information Manual or call the Laboratory.

OTHER TESTS (Please Print)

URGENT

CHEMISTRY/HEMATOPATHOLOGY TEST REQUISITION

LABORATORY TEST REQUEST MISCELLANEOUS

a an operating division of the Winnipeg Regional Health Authority

CANADIAN BLOOD SERVICES

WINNIPEG CENTRE

777 William Ave. Winnipeg, MB. R3E 3R4

REQUEST FOR BLOOD COMPONENTS

☐ Red Cell Request # of Units _____

☐ Platelet Request # of doses _____

Tests	Priority	Special Handling
☐ Type and Screen	☐ Routine	☐ Neonatal Protocol
☐ Crossmatch	☐ OR	☐ Anti-CMV Negative
☐ Direct Antiglobulin Test	☐ PAC	☐ Irradiated
	☐ STAT	☐ Autologous
		☐ Directed
		☐ Other _____

Date Required _____ Time _____

Ordering Physician _____

Diagnosis _____

Has Patient received RhIG in the last three months? ☐ Yes ☐ No

Where _____ Date _____

Directed Recipient _____ PHIN _____

Male ☐ Female ☐

Collected at

Facility _____ Ward _____

Send Components/Report to (if different than above)

Facility _____ Ward _____

Phlebotomist

Print Name _____ Classification _____ Initials _____

Collection Date _____ Time _____

Sample Requirements

- Adults 1 X 7 mL EDTA (lavender top)
- Children 1 X 5 mL EDTA (lavender top)
- Infants 1 - 2 mL EDTA (lavender top)

Collection Procedure

Step	Action
1	**The phlebotomist must positively identify the patient by comparing the following information on the requisition with the information on the patient's wristband, if available,** • Personal Health Identification Number (PHIN), or hospital number, (if PHIN is not available or patient is from out of province), or other unique identification number, and • the patients first and last name.
2	**The phlebotomist must collect the appropriate sample(s).**
3	**The phlebotomist must label the sample(s) using indelible ink. Label the sample(s) immediately after the collection and before leaving the patient's side with** • Personal Health Identification Number (PHIN), or hospital number, (if PHIN is not available or patient is from out of province), or other unique identification number • the patients first and last name • the collection date • facility name, and • phlebotomist's initials.
4	**The phlebotomist must complete the requisition by** • printing his/her name, classification, and initials, and • recording the date and time of collection.

Error Correction

The phlebotomist should correct errors at the time of collection by

- crossing out the erroneous information with a single line
- recording the correct information, and
- initialling the correction.

Date / Time Received at Facility Blood Bank

Date / Time Received at Centre

Samples Not Tested

Sample(s) may not be tested if

- information is missing or incorrect on the sample or requisition
- correction fluid is used to correct errors, or
- the sample has been overlabeled.

HOSPITAL COLLECTION RECORD

XM101 05/09

RECORD OF SPECIAL TREATMENTS AND TESTS

DATE ______________________ WARD ______________________

ROOM	PATIENT	TREATMENT & TESTS	TIME	DONE BY