

LAB

	Time/ORD	Initials	Time Sent/Drawn	Initials
<input type="checkbox"/> Amylase	_____	_____	_____	_____
<input type="checkbox"/> ABG	_____	_____	_____	_____
<input type="checkbox"/> Bili Sgot	_____	_____	_____	_____
<input type="checkbox"/> BMP	_____	_____	_____	_____
<input type="checkbox"/> Cardiac enz	_____	_____	_____	_____
<input type="checkbox"/> CBC	_____	_____	_____	_____
<input type="checkbox"/> CMP	_____	_____	_____	_____
<input type="checkbox"/> Digoxin	_____	_____	_____	_____
<input type="checkbox"/> Liver panel	_____	_____	_____	_____
<input type="checkbox"/> Preg-Ur/Se	_____	_____	_____	_____
<input type="checkbox"/> PT PTT	_____	_____	_____	_____
<input type="checkbox"/> Quant HCG	_____	_____	_____	_____
<input type="checkbox"/> TSH T4	_____	_____	_____	_____
<input type="checkbox"/> Rapid Strep	_____	_____	_____	_____
<input type="checkbox"/> U/A	_____	_____	_____	_____
<input type="checkbox"/> R/O MI	_____	_____	_____	_____
<input type="checkbox"/> Trauma Panel	_____	_____	_____	_____
<input type="checkbox"/> Wet Prep	_____	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____	_____

DIAG. IMAG

	Time/ORD	Initials
<input type="checkbox"/> Port CXR	_____	_____
<input type="checkbox"/> X tbl C Spine	_____	_____
<input type="checkbox"/> PA & Lat CXR	_____	_____
<input type="checkbox"/> Flat & up abd	_____	_____
<input type="checkbox"/> KUB	_____	_____
<input type="checkbox"/> CTL Spine	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/> CT	_____	_____
r/o _____	_____	_____
<input type="checkbox"/> CT	_____	_____
r/o _____	_____	_____
<input type="checkbox"/> US	_____	_____
r/o _____	_____	_____
<input type="checkbox"/> MRI	_____	_____
r/o _____	_____	_____
MODE OF TRANSPORT for DID: <input type="checkbox"/> WALK <input type="checkbox"/> W/C <input type="checkbox"/> CART		
TIME TO DI: _____ TIME RETURNED TO ED: _____		

MICRO

	Time/ORD	Initials
<input type="checkbox"/> GC Screen	_____	_____
<input type="checkbox"/> Chlamydia	_____	_____
<input type="checkbox"/> Urine C & S	_____	_____
<input type="checkbox"/> Blood X _____	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____

RT

	Time/ORD	Initials
<input type="checkbox"/> EKG	_____	_____
<input type="checkbox"/> Alb. Neb.	_____	_____
<input type="checkbox"/> Atrovent _____	_____	_____
<input type="checkbox"/> Rac. Epi _____	_____	_____
<input type="checkbox"/> Peak Flows	_____	_____
<input type="checkbox"/> Holter	_____	_____

PHYSICIAN ORDERS & OUTCOMES

Time Ordered	Procedure/Med/Fluid/DOSE/ROUTE/RATE	Time Started	Initials	Outcome	Stop Time	Initials
	DT Lot # Exp Date:					

ALLERGIES: Latex NKDA

* = See Nurses Addendum

RN Signature_____
MDs Signature_____
Tech Signature