Paperwork for the Busy Interventionalist: The Basic Six

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ABSTRACT

Communication and patient care go hand in hand. Unfortunately, due to time constraints direct verbal communication with health care providers in every instance is not practical; it is also inefficient. Documentation is mandated by the Joint Commission on Accreditation of Healthcare Organizations and hospital bylaws. It reduces ambiguity and actually speeds communication between physician and hospital staff. Standard paperwork is recommended in most cases. Forms for patient admission, history and physical examination, daily patient rounds, preprocedural orders, consent form, discharge summary, and discharge orders allow the busy interventionalist to multitask with reasonable efficiency and fewer mistakes.

KEYWORDS: Standard forms, interventional radiology, paperwork, patient care

Objectives: Upon completion of this article, the reader should (1) become familiar with ways to efficiently respond to a consult, document findings, make recommendations, and communicate with nurses and staff and (2) find examples of standardized forms that can save time, improve efficiency, and lower the risk of making mistakes and being misunderstood.

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Basic paperwork is mandated by hospital bylaws and reviewed periodically by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) audits; it is also a simple and effective means of communicating with physicians, nurses, laboratory staff, and others. There are established forms of communication necessary for patient care that will be reviewed in this article.

The management of the interventional radiology patient certainly involves more than simple paper work. However, there are six basic forms that can greatly increase efficiency, allowing the interventionalist to see the patient, perform the history and physical, and write

preprocedural and admission orders, all within a 15-minute period. Use of physician extenders, fellows, and residents can further increase efficiency.

To perform as effectively as any other admitting physician begins with knowing what to write and order. This requires some advance preparation before patient arrival. Preprinted forms can be valuable in improving organization, readability, and efficiency, as well as making sure no detail is overlooked. When developing these forms, it is important to be aware of the essential information required in each section, as determined by Medicare, billing, JCAHO, and hospital bylaws. Obtain and familiarize yourself with a copy of your hospital

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OSF[®]
SAINT FRANCIS MEDICAL CENTER**ADULT POST ANGIO
PREPRINTED ORDERS**

Form No. 113-1245 (Rev. 05/06)

Page 1 of 2

Height:	Weight:	PHYSICIANS ORDERS ADULT POST ANGIO
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- ☒ Admit to Dr. _____
☐ Observation Status ☐ Ambulatory Status ☐ Inpatient Status
☒ Notify Dr. _____ of admission
 Intervention to ☐ right ☐ left ☐ upper ☐ lower extremity

ASSESSMENT & MONITORING

- ☐ Check vitals, extremity pulses and for neurovascular changes now, then every 15 minutes times four, then every 30 minutes times four, then hourly times four
- ☐ Check ☐ right ☐ left ☐ groin ☐ brachial puncture site for hematoma, extremity for neurovascular changes, and extremity pulse now, then every 15 minutes times two, then every 30 minutes times four, then hourly times four
- ☒ Call Interventional Radiology and apply pressure for hematoma
- ☒ Call Dr. _____ or Interventional Radiologist on call for:
- > Systolic BP greater than _____ or less than _____
- > Pulse greater than _____ or less than _____

Brachial artery puncture sites

- ☒ Patient to have arm in sling for 6 hours, do not use arm
- ☒ Bed rest for 6 hours, head of bed may be elevated
- ☒ Make patient aware to notify nurses if experiencing numbness, tingling, or pain in hand on the side where brachial artery puncture occurred (median nerve can become compressed)
- ☒ Call Interventional Radiology for
 - Numbness, tingling, or pain in their hand
 - Weak grip, with close attention to the first three digits

ACTIVITY

- ☐ Bedrest (HOB up no more than 30 degrees), _____ leg/arm straight times _____ hour(s). May log roll.
☐ If no bleeding or hematoma at puncture site, activity as tolerated after _____ (time)
☐ Assist with first ambulation post procedure
☐ May immobilize _____ extremity times _____ hours
☐ Pressure dressing to _____ times _____ hours
☒ If bleeding occurs, apply pressure and call Dr. _____ or Interventional Radiologist on call

NURSING

- ☐ May insert foley if unable to void, discontinue when ambulating
- ☐ Record urine output

DIET

- ☐ Resume previous diet as tolerated
- ☐ Usual home diet as tolerated
- ☐ Encourage PO fluids

IV FLUIDS

- ☐ NS @ _____ ml / hr times _____ hours, then saline lock
☐ Saline Lock
☐ IV orders per _____
☐ IV of _____ @ _____ ml / hour
☐ Sodium Bicarbonate 150 mEq/1000ml D₅W; run at 1ml/kg/hour. **Stop 6 hours post procedure at**

Physician Signature: _____ Dictation #: _____
Date/Time: _____

Figure 1 Postprocedural order form.

**ADULT POST ANGIO
PREPRINTED ORDERS**
Form No. 113-1245 (Rev. 05/06)
Page 2 of 2

Height: Weight:

**PHYSICIANS ORDERS
ADULT POST ANGIO**

MEDICATIONS

- ☐ Resume previous orders per Dr. _____
- ☐ Resume home meds per Dr. _____
- ☒ Hold metformin (Glucophage), glyburide/metformin (Glucovance), glipizide/metformin (Metaglip), rosiglitazone/metformin (Avandamet), actos/metformin (ActoplusMet) for 2 days post procedure
- ☐ _____
- ☐ _____

Heparin

- ☐ Bolus _____ units Heparin IVP
- ☐ Start Heparin 25,000 units / 500 ml D₅W at _____ units / hour
- ☐ Neurology (low bolus) Sliding Scale (see pre-printed orders)
- ☐ Resume Heparin at previous rate at _____ hours post successful sheath removal
- ☐ Call _____ for heparin orders

Analgesia

- ☐ Acetaminophen (Tylenol) 325 mg 2-3 tabs PO every 4 hours PRN for pain
- ☐ Acetaminophen 300 mg with Codeine 30 mg (Tylenol #3) 1-2 tabs PO every 4-6 hours PRN for pain
- ☐ Propoxyphene Napsylate 100 mg with acetaminophen 650 mg (Darvocet N100) 1-2 tabs PO every 4-6 hours PRN for pain
- ☐ Hydrocodone 5 mg with acetaminophen 500 mg (Vicodin) 1-2 tabs PO every 4-6 hours PRN for pain
- *DO NOT EXCEED 4000 MG ACETAMINOPHEN IN 24 HOURS***
- ☐ PCA Pump (see preprinted orders)

Other

- ☐ Ondansetron (Zofran) 4 mg IV times 1 PRN (See antiemetic orders for treatment of nausea & vomiting)
- ☐ Lorazepam (Ativan) 0.5 mg IV/PO every 6 hours PRN for anxiety
- ☐ Temazepam (Restoril) 15 mg PO every HS PRN for sleep; may repeat times 1

LABS / DIAGNOSTIC TESTING

- ☐ Arterial vascular study of _____ in AM, Status Post Angioplasty and/or stent of _____ Preliminary report on chart. Please include waveforms in report. Call results to nurse clinician.
- ☐ NPO after 2200 in preparation for vascular ultrasound in AM

AM Labs

- ☐ Creatinine
- ☐ H & H
- ☐ _____
- ☐ _____

DISCHARGE

- ☐ Plan for discharge after _____ (time) if stable, able to void and ambulate without pain, bleeding, hematoma at puncture site.
- ☐ Call Radiology nurse clinicians for discharge orders prior to 1700. Call Interventional Radiologists on call after 1700.
- ☐ May discharge with pressure dressing intact.

Physician Signature:

Dictation #:

Date/Time:

Figure 1 (con't)

bylaws to ensure that hospital-specific requirements are met. Necessary references, such as billing codebooks and the Society of Interventional Radiology syllabus, should be made readily available.

Furthermore, an efficient system requires solid teamwork. Guidelines should be developed detailing how each patient is approached. Team members must be trained and updated on any changes to protocol. These guidelines should address which preprinted forms need to be present in the patient's chart and the information that must be gathered prior to the interventionalist seeing the patient, including the appropriate laboratory workup and salient reports. At our institution, before the patient arrives, the appropriate imaging reports, laboratory results, prior history and physical examinations, and relevant reports from other physicians are collected and organized in the patient's chart. By the time the patient arrives at our preprocedural area, registration and laboratory blood draws have already been completed. The nursing staff gowns the patient, assesses and records vital signs, completes a nursing evaluation, and documents laboratory values when they become available.

The postprocedural order form (Fig. 1), history and physical form (Fig. 2), and procedural consent form (Fig. 3) have all been appropriately labeled and are ready to be completed. The interventionalist need only arrive punctually, review the chart information, perform a focused history and physical examination, and document the findings on our streamlined form. Informed consent is then obtained and the preprocedural orders are completed (Fig. 4). Once the patient has been treated and admitted, daily notes are written on the chart specifically addressing interventional radiology and other medical issues. When the patient is ready for discharge, a dictated discharge summary is added to the chart and discharge orders written. This should satisfy 95% of necessary chart documentation.

THE HISTORY AND PHYSICAL EXAMINATION

A targeted history and physical is usually all that is required. The interventional radiologist usually knows what the problem is before seeing the patient. This information is communicated to us by the requesting physician or the patient has previously been seen in our outpatient office. The disease processes are familiar to us (e.g., peripheral vascular disease) and the patient's chief complaints are usually straightforward (e.g., "leg aches when I walk"). I cannot stress enough the importance of simple, easy-to-fill-out history and physical examination form. This can save a lot of time and still meet the basic requirements. Check boxes on the form are a plus! A detailed description of all the necessary aspects of a complete history and physical examination is given below for reference as needed.

The basic sections of a history and physical examination (Fig. 2) include the chief complaint, history of present illness, previous medical and surgical history, allergies, medications, social history, family history, review of systems, physical examination (including a vascular examination), laboratories and imaging results, impression, and plan. For interventional radiology, some of the most important pieces of data to be addressed include: location of symptoms (for planning access and therapy), medications (e.g., Metformin, which may need to be stopped for 24 hours, or blood thinners), allergies (especially to contrast; information about pretreatment if one is present), blood urea nitrogen (BUN) and creatinine (as an estimate of contrast tolerance), and prothrombin time (PT)/international normalized ratio (INR) (for postprocedural hemostasis).

As a reminder, the chief complaint must represent a symptom, not a diagnosis, and is often in the patient's own words. The history of present illness should elaborate on the chief complaint, addressing details such as location, severity, exacerbation, time course, associated/absent symptoms, and any associated conditions or surgeries related to the chief complaint. The previous medical history should include a list of diagnoses, and the surgical history contains a list of prior procedures including dates performed. As discussed above, allergies and medications are very important to be aware of. Social history should include marital status and the use of alcohol, drugs, or tobacco. Family history should address medical conditions related to the chief complaint in family members. The review of systems is a systems-based review of symptoms and conditions, including documentation of pertinent negatives. This serves to remind the patient of information that they may have forgotten to mention earlier during the interview.

The physical examination is performed to substantiate hypotheses generated by the history and obtain further information concerning the specifics of the patient's complaint to arrive at an accurate diagnosis and treatment plan. The physical examination also serves to alert the interventionalist to any comorbidity, which may require alteration of the proposed therapy or adversely affect outcome. The focused subspecialty physical examination should include the basic elements of the general physical examination but also elaborate on the presenting complaint as well as assess for any physical factors that may affect the planned intervention. The examination begins with vital signs and an assessment of the patient's overall well-being and then moves on to specific systems. The cardiovascular examination assesses rate, rhythm, and quality of heartbeat; the pulmonary examination evaluates respiratory characteristics; the abdominal examination appraises bowel sounds, tenderness, or distention; the neurological examination documents any preexisting deficits; the extremity examination with vascular examination assesses edema, skin changes,

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History and Physical Examination / Short

Form No. 113-3181 (2/05)
page 1 of 1

Patient Name: _____ Birthdate: _____ Sex: _____
Chief complaint: _____

History of Present Illness/Indication(s) for Procedure: _____

Past History/Current Medical Condition: _____

Family/Social History: _____ Smoking ☐ Y ☐ N
Alcohol ☐ Y ☐ N

Current Medications: _____

Allergies: _____ Latex ☐ Y ☐ N Unknown: _____

Adverse Reactions to Anesthesia: _____ ASA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Review of Systems (review any pertinent positives and negatives): _____

Physical Exam:

Blood Pressure:	Pulse:	Temp:	Height:	Weight:
	Normal	Abnormal	Explanation	
Minimum Required:				
HEENT:				
Lungs:				
Heart:				
Abdomen:				
Neurological:				
Extremities:				
As Appropriate:				
Neck:				
Back and Thorax:				
Breast:				
Pelvic:				
Rectal:				
Integument:				
Other:				

Assessment/Diagnosis: _____ ☐ See reverse side for additional information

Plan: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

(☐ Updated – no changes) PHYSICIAN'S SIGNATURE: _____ DATE: _____

(☐ Updated – see progress note for changes) PHYSICIAN'S SIGNATURE: _____ DATE: _____

Figure 2 History and physical form.

Consent To Surgery/Procedure

FORM NO. 113-0672 (REV. 08/05) MS
PAGE 1 of 2**CONSENT TO SURGERY/ PROCEDURE**

I _____ hereby authorize Dr. Brady, Bertino, Fraser,
Hassan, Johnson, Fahey, Martin, Meagher, Moresco, Smouse, Swischuk, Wang, Zagardo _____

and such assistants and associates as may be selected by him/her and OSF Saint Francis Medical Center to perform the following procedure(s)/ treatment(s) upon myself/the patient: _____

Aorta and Right / Left / Bilateral Lower Extremity Arteriogram with possible Thrombolysis, Angioplasty,
Stenting _____

Stated in Medical Terminology

Dye study with x-ray pictures of leg arteries with possible clot busting medicine, balloon dilatation, placement of
wire mesh tube to hold artery open _____

Stated in Common Language

2. I understand that this procedure(s)/treatment(s) appears indicated by the diagnostic and/or observations performed. My physician has explained to me the following:
 - A. The nature of the proposed procedure, care, treatment, services, medications, or interventions.
 - B. The purpose of and need for the recommended procedures(s)/treatment(s).
 - C. The potential benefits, risks, side effects, including potential problems related to recuperation.
 - D. The alternatives, if any to the recommended procedure(s)/treatment(s), service, or care. I understand the explanation provided and give this consent voluntarily.
 - E. The relevant risk, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services.
3. I understand that the explanation I have received is not exhaustive and I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/treatment(s).
4. I agree to allow the performance of additional procedure(s)/treatment(s) as deemed necessary by my physician during the course of this procedure(s)/treatment(s).
5. I agree to allow the use of anesthetics/anesthesia agents by the healthcare professionals responsible for their administration and have been fully advised by them as to the nature/purpose of the planned anesthesia, the possible risks and/or complications of anesthesia and possible alternative methods. I have been fully advised of the above prior to the procedure(s)/treatment(s) and anesthesia episode.
6. I agree to imagery of the procedure(s).treatment(s) such as for educational and performance improvement or scientific purposes. I realize my identity may become apparent.

Figure 3 Procedural consent form.

Children's
Hospital
of Illinois

FORM NO. 113-0672 (REV. 08/05) MS
PAGE 2 of 2

11. I have read this consent form in its entirety, understand its content and significance, have had all my questions answered and have no further questions.

Time:_____

Relationship: _____

Physician: _____

To be completed prior to the procedure(s)/treatment(s) at the place where the procedure(s)/treatment(s) takes place. (Surgery and other approved departments may use their own "correct site surgery checklist"). This should be done with patient agreement unless the patient is sedated or unable to participate.

- Relevant documents and studies have been reviewed prior to the procedure that includes the following as applicable:
 - History and Physical (H&P within 24hrs for new admit. Progress notes serve as update/H&P within 30 days for Am admit or OP surgery requiring update at time of admission)
 - Imaging reports
- Site is marked with assistance from the patient, when possible. Applicable when procedure involves laterality, multiple structures (fingers, toes, lesions) or multiple levels (spine).
- The following are checked immediately prior to incision/injection/procedure:
 - Correct Patient Identity
 - Correct Side and Site
 - Agreement on the procedure to be done
 - Correct patient position
 - Correct implants, special equipment or special requirements needed are available and prepared.

Time: _____

Signature

Figure 3 (con't)

**ADULT PRE ANGIO
PREPRINTED ORDERS**
Form No. 113-1264 (Rev. 08/04)
Page 1 of 1

Height:	Weight:	PHYSICIANS ORDERS PRE ANGIO
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DIAGNOSIS: _____

- ☒ Please have patient sign consent for _____
to be done by Dr. Brady, Dr. Bertino, Dr. Fraser, Dr. Smouse, Dr. Swischuk, Dr. Zagardo, Dr. Hassan,
Dr. Moresco, Dr. Brad Johnson, or Dr. Wang
- ☐ Clear liquid breakfast, then NPO after _____ except for PO meds
- ☐ NPO per anesthesia guidelines for appropriate age
- ☒ Please order labs below as checked if not already obtained:
☐ Creatinine	☐ Fibrinogen	☐ Potassium	Pregnancy: ☐ Serum
☐ BUN	☐ H & H	☐ PT	☐ Urine
☐ CBC	☐ Platelets	☐ PTT	
☐ Bleeding Time	☐ BMP	☐ Other _____	
- ☒ Report abnormal lab results to Angio (5-3478) or to the Interventional Radiologist on call
- ☒ Have patient void on call to Angio
- ☐ Start 1000ml NS IV at _____ ml/hour
- ☐ Sodium Bicarbonate 150 mEq/1000 ml D5W; run at 3 ml/kg/hour times one hour, then decrease to 1ml/kg/hour times 6 hours or until discharge.
- ☒ Notify Angio (5-3478) if patient is on warfarin (Coumadin), metformin (Glucophage), clopidogrel (Plavix), or metformin/glyburide (Glucovance)
- ☐ Hold metformin (Glucophage), glyburide/metformin (Glucovance), glipizide/metformin (Metaglip), rosiglitazone/metformin (Avandamet) for 2 days post procedure
- ☒ Notify Angio (5-3478) if patient has dye / contrast allergy
- ☒ Stop Heparin ☐ On call to Angio ☐ at _____
- ☒ ASA Risk Classification
☐ Class I	☐ Class II	☐ Class III	☐ Class IV	☐ Class V
- ☒ Prior to procedure: Capillary blood glucose (Accucheck) all patients taking diabetes medications.
- ☐ Hypoglycemic Management Protocol
- ☐ Diphenhydramine (Benadryl) 50 mg PO 1 hours prior to angiogram
- ☐ Prednisone 50 mg PO at 13, 7 and 1 hour prior to angiogram
- ☐ Acetylcysteine (Mucomyst) 600 mg BID 24 hours prior to angiogram
- ☐ Fenoldopam (Corlopam) Infusion 10mg/250ml; run at 0.1 micrograms/kg/min

Physician Signature:	Dictation #:
Date/Time:	

Figure 4 Preprocedural order form.

or ulceration. The head, eyes, ears, nose, and throat examination is performed when appropriate. Finally, focused examination is performed of any pertinent body parts for which the patient is being seen.

Laboratory data should be reviewed to identify abnormalities that may affect the intended intervention. Important values include PT/PTT (partial thromboplastin time)/INR and platelet level (for post-procedural hemostasis), BUN and creatinine (as an estimate of contrast tolerance), and electrolyte abnormalities. BUN and creatinine may determine whether carbon dioxide or Visipaque is used in lieu of standard contrast. In some cases, a temporary vascular access may be placed instead of tunneled access if the INR is severely elevated.

PREPROCEDURAL ORDERS

The preprocedural order and note can be handled as a standardized form (Fig. 4) in most cases. Some orders are universal to every case, although others are tailored to specific types of cases (e.g., angiograms, biopsies, or dialysis). The order sheet will need to satisfy your hospitals' particular bylaw requirements. The form shown in Fig. 4 used for our outpatients is detailed and should satisfy most hospitals. For inpatients the physician extender or physician writes a focused note, one paragraph in length, stating the history and chief complaint of the patient as well as a discussion of the procedure (either detailed or in general terms) and a sentence describing that the risks, benefits, and alternatives were discussed with the patient and informed consent was obtained. Premedication (including antibiotics), hydration, intravenous access needs, ASA score (American Society of Anesthesiologists risk score), and preprocedural laboratory work and imaging should be addressed.

CONSENT FORM

An example is given (Fig. 3) that highlights the necessities, again governed by your hospital bylaws. The requirements at our hospital include: name of the patient, technical description of procedure, description of procedure in laymen's words, date, signature of patient or authorized representative and the relationship of the authorized representative to the patient, person obtaining consent, and drug allergies of the patient. The consent form will also have general statements and consents to administer blood products or other medications as deemed necessary by the treating physician. Your hospital will likely have an alternate consent form for Jehovah's Witness patients.

ADMISSION NOTE

A senior resident passed this formula to me when I was a medical student. It is simple to remember and uses a

nearly universal format. Just remember: ABC VAN-DALISM.

Admit: to whom; which unit; full or 23-hour observation (when in doubt use full admit)

Because (diagnosis): reason for admission

Condition: stable, unstable, guarded, or critical

Vital signs: type, frequency, and parameters for MD notification

Allergies: drug, food, tape, latex

Nursing duties: drain management, weights, intake and output

Diet: requirements/restrictions; nothing by mouth after midnight except for medications with sips of water

Activity: type and limitations, duration and frequency, position

Laboratories: preoperative, BUN, creatinine, coagulation profile, hemoglobin, and hematocrit

Intravenous fluids: types, rates, duration

Special: includes imaging (chest x-ray, ultrasound, and so on; when and reason) and consults (diagnosis, reason; call all consults)

Medications: home meds, additional meds, sleep, anxiety, anticoagulation, Plavix, and prophylaxis (anti-ulcer, deep vein thrombosis, antibiotics)

Talking with the patient's nurse and answering any questions he or she may have will save you from phone calls in the middle of the night. Remember that requirements for admission orders are hospital bylaw-specific, so obtain and familiarize yourself with a copy of your hospital bylaws. This order format should be adequate for most purposes.

DAILY NOTES

The daily note should be a brief update of the patient's status and allows for communication of the assessment and treatment plan between the different caregivers. We have used the SOAP (subjective, objective, assessment, and plan) note format for over a decade without any significant problems. Some physicians use preprinted, formatted SOAP notes for improved readability and efficiency.

Subjective: how patient perceives his status, any new complaints, issues, or questions. Better, same, or worse.

Objective: vital signs, limited physical examination, laboratory and imaging results, input and output and description drain including site evaluation, culture/biopsy results. Limb evaluation when needed, groin puncture site evaluation. Include comparison to prior results, if relevant.

Assessment and Plan: these are usually lumped together as a problem-based list, starting with the interventional radiology-specific concerns. Each problem is

followed by an assessment of the situation as well as the planned course of action, both diagnostic and therapeutic. A detailed list of all the medical problems is usually not needed unless the patient is your admission. A simple statement such as “hypertension—patient to take home meds” is appropriate.

DISCHARGE SUMMARY

Begin with a brief summary of the reason for admission with any pertinent symptoms, history items, physical, laboratory, or imaging findings on admission. The hospital course should include consultations, diagnostic and therapeutic procedures, and any pertinent physical, laboratory, or imaging findings during the course of the patient's hospital stay, as well as patient outcome. The final section includes the patient's disposition (e.g., to home or nursing facility), disposition condition, and a short summary of the highlights of the discharge orders, including changes to medication and follow-up studies or appointments. Many times the follow-up appointment to your office will not be scheduled at time of discharge. A statement such as “interventional radiology office to call patient and schedule follow-up” is appropriate.

DISCHARGE ORDERS

Include continued, discontinued, new, or adjusted medications (including dose, frequency, and duration of new

medications), new medicine prescriptions, dietary and activity restrictions, wound and drain care instructions, and follow-up imaging, laboratories, or appointments. Phone numbers should be provided for contacts to address patient questions, problems, or concerns. For an overnight stay for, say, a renal stent, I will give the following restrictions: “Patient to resume normal activity immediately but no heavy lifting for 3 days, that is, nothing heavier than a gallon of milk. Have patient contact emergency room or call hospital and have interventional radiologist paged if swelling occurs at groin puncture site, fever greater than 100°F, severe flank pain, or syncope.”

CONCLUSION

As you can see not a lot of forms are needed in the general management of the uncomplicated admitted patient. By memorizing and becoming comfortable with six basic forms, you should be able to handle the majority of admissions and necessary documentation without great effort or angst. Most interventional radiology practices have other detailed order forms for chronic cases, such as thrombolysis, pain management (personal controlled anesthesia forms), heparin sliding scale, and others. These have not been addressed specifically because they are not directly related to patient admission and are used more for disease management.