McLaren Flint

DEPARTMENT OF RADIOLOGY
SPECIAL PROCEDURES LOG

Date _____

Procedure _____

Check one: Radiologist _____
Tech _____
Nurse _____

Check all: ❑ I.D. Verification
❑ Consent Signed
❑ ORD

Anticoagulants _____

Allergies _____

_____

Pregnant: ❑ Yes ❑ No

Check any that apply:

❑ Dentures ❑ Asthma ❑ Diabetic
❑ Glasses ❑ Emphysema ❑ HPB
❑ Hearing Aid ❑ Cardiac

Related Surgeries _____

_____

Previous Contrast ❑ Yes ❑ No

Time	Location/Rate/AMT.
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

–ATTACH PATIENT TREND STRIP–

Patient I.D. _____

Lab Results

PT _____ PTT _____ INR _____
HGB _____ HCT _____ FIB _____
BUN _____ CREAT _____ PLT _____

Contrast Type _____

Amount Opened _____

Fluoro TIme _____

❑ Patient in Room _____
❑ Patient Ready _____
❑ Procedure Started _____
❑ Procedure Completed_____
❑ Post-Procedure Instructions_____
❑ Discharge Time _____

Time	Medication	B/P
_____		
_____		
_____		
_____		
_____		

Pre-procedure:

Pulse _____ B/P _____ 02 SAT. _____%

Post-procedure:

Pulse _____ B/P _____ 02 SAT. _____%

	INFT-ECG-PULSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PT.

MR.#/RM.

DR.