

✓	NEUROLOGICAL DEFICIT ORDERS – EMERGENCY DEPARTMENT	ROOM NO. _____
ALLERGIES (list reactions):		HT _____ (Cm) WT _____ (Kg)
A <input checked="" type="checkbox"/> indicates a selected order. If a defaulted order is not appropriate or there is a change to an order, draw a line through the order and initial.		
Diagnosis: Neurological deficit		
Nursing:		
<input checked="" type="checkbox"/> Assess neurologic status, Q 15 min x 4 <input checked="" type="checkbox"/> Cardiac Monitor <input checked="" type="checkbox"/> Blood glucose, point-of-care measurement, notify physician if glucose is < 75 mg/dL and altered mental status <input type="checkbox"/> Start IV with 18 gauge needle <input type="checkbox"/> RN to draw labs and hold for type and screen <input type="checkbox"/> RN to draw labs and hold for Platelet Function Assay (PFA) <input type="checkbox"/> RN to draw labs and hold for Fibrinogen level (FIB) <input checked="" type="checkbox"/> Continuous pulse oximetry <input checked="" type="checkbox"/> Oxygen via nasal cannula at 2-4 l/min as needed to maintain SpO2 > 95% <input checked="" type="checkbox"/> NPO		
LAB/Procedures:		
<input type="checkbox"/> Pregnancy test, urine, point-of-care measurement (HCGU) <input checked="" type="checkbox"/> Troponin (TROP), <input checked="" type="checkbox"/> CBC, <input checked="" type="checkbox"/> ESR, <input checked="" type="checkbox"/> aPTT, PT <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> Toxicology drug screen, urine (DRGU) <input checked="" type="checkbox"/> CXR (1View). Reason for exam: focal neurological deficit <input checked="" type="checkbox"/> 12-lead EKG. Reason for exam: focal neurological deficit <input checked="" type="checkbox"/> CT of head without contrast. Reason for exam: focal neurological deficit		
For Hyperacute stroke without hemorrhage on CT:		
<input type="checkbox"/> CT angiography of head with and without contrast <input type="checkbox"/> CT perfusion of head with and without contrast <input type="checkbox"/> CT angiography of neck with and without contrast		
Medications:		
<input type="checkbox"/> 0.9% NaCl to run at 100 mL/Hr, or <input type="checkbox"/> IV _____ to run at _____ mL/Hr		
12-hour Chart Check _____ RN DATE: ____ / ____ / ____ TIME: _____		
T.O. _____ Taken by: _____ / ____ / ____, TIME: _____		
TRANSCRIBED BY: _____ / ____ / ____, TIME: _____ NOTED BY: _____ / ____ / ____, TIME: _____		
PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____		
PRINTED NAME/ID#: _____	(COUNTER-SIGN ALL T.O. ORDERS WITHIN 48 HOURS, AND INCLUDE THE DATE/TIME AUTHENTICATED)	



NEUROLOGICAL DEFICIT ORDERS – EMERGENCY DEPARTMENT

PATIENT ID