

**REMINDER: ALL MEDICATION ORDERS REQUIRE DOSE, ROUTE, FREQUENCY AND INDICATION
DO NOT USE ABBREVIATIONS**

DOCTORS ORDERS	CHECK OFF/ INITIALS
PRE MEDICATION FOR PATIENTS WITH A HISTORY OF IV CONTRAST REACTION	
Prior Contrast Reaction Classification: Mild _____ Moderate _____ Severe _____	
Preparation to begin: 24 hours. pre-procedure Date: _____ Time: _____ a.m. _____ p.m.	
12 hours. pre-procedure Date: _____ Time: _____ a.m. _____ p.m.	
Steroid: Name: Deltasone (Prednisone®) Dose: 20mg Route: By Mouth Frequency: 2 times a day prior to test and one dose morning of test	
Name: Diphenhydramine(Benadryl®): Route: By Mouth Dose: 25mg Frequency: 2 times a day prior to test and one dose morning of test	
H2 Blocker: Name: Cimetidine (Tagamet®) Dose: 300mg Route: By Mouth Frequency: 2 times a day and morning of test	
MD must be notified pre-procedure if prep is incomplete	
Physician/Date/Time: _____	Nurse/Date/Time: _____
Secretary/Date/Time: _____	

Full page of orders requires only one physician, one nurse and one clerical signature



Original to Patient's Chart

Fax to Pharmacy