Alberta Health Services

Form Title **Minor Head Injury, Adult - Emergency**

Form Number **20998-bond**

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Alberta Health Services

Last Name	
First Name	
PHN#	MRN#
Birthdate *(dd-Mon-yyyy)*	Physician

Minor Head Injury, Adult - Emergency

Select orders by placing a (✓) in the associated box

For more information, see Clinical Knowledge Topic ***Minor Head Injury Adult - Emergency Department***
http://insite.albertahealthservices.ca/klink/14163.asp

Allergies

Goals of Care

Goals of Care Designation

☐ Goals of Care Designation ____________________

Patient Care

Monitoring

☐ Vital Signs: These orders need to be re-evaluated when the patient stabilizes or by two hours, whichever occurs first.
- ☐ as per provincial guideline
- ☐ every _______ hourly
- ☐ every _______ minute(s)
- ☐ Continuous cardiac monitoring

☐ Neurological Vital Signs: These orders need to be re-evaluated when the patient stabilizes or by two hours, whichever occurs first. Neurological Vital Signs to include Glasgow Coma Scale (GCS), and pupillary size and reaction to light with reassessments.
- ☐ as per provincial guideline
- ☐ every _______ hourly
- ☐ every _______ minute(s)
- ☐ Note: The physician should be notified if a patient's GCS decreases by 2 points.

Diet/Nutrition

☐ NPO
☐ Clear fluid
☐ Other Diet: ____________________
☐ NPO – May Have Sips, May Take Meds
☐ Regular Diet

Laboratory Investigation

Hematology

☐ Complete Blood Count (CBC)
☐ PT INR

Chemistry

☐ Electrolytes (Na, K, Cl, CO_2)
☐ Glucose Random
☐ Creatinine

Urine Tests

☐ Urine Dipstick Testing - POCT
☐ Urinalysis Random
☐ Urine Culture & Sensitivity
☐ Pregnancy Test, Urine - POCT

Drug Levels / Toxins

☐ Acetaminophen LEVEL ☐ Ethanol LEVEL ☐ Salicylate LEVEL

Prescriber Signature	Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

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Diagnostic Investigation

☐ CT Head *(if criteria met – see Table 1)* Reason ______________________________
☐ X-ray Cervical Spine, 1 - 4 Views
☐ CT Cervical Spine
- *Consider CT Cervical spine in high-risk mechanism or inadequate plain film radiography*

Other Investigation

☐ Electrocardiogram -12 Lead *(ECG)*

Fluids/Electrolytes

IV Maintenance
☐ Intravenous Cannula - Insert: Initiate IV
☐ IV Peripheral Saline Flush/Lock: Saline Lock

IV Fluid Infusions:
☐ 0.9% NaCl infusion at _____ mL/hour
☐ Other __________ infusion at _______ mL/hour

Medications

Antiemetics

***Avoid dimenhyDRINATE in patients 65 years of age or older due to increased risk of side effects including delirium. Suggest 25 mg for mild/moderate nausea, 50 mg for moderate/severe nausea*

☐ dimenhyDRINATE 50 mg PO once
☐ dimenhyDRINATE 25 to 50 mg PO every 4 hour PRN for nausea/vomiting
☐ dimenhyDRINATE ______ mg PO ____________________

☐ dimenhyDRINATE 50 mg IV once
☐ dimenhyDRINATE 25 to 50 mg IV every 4 hour PRN for nausea/vomiting
☐ dimenhyDRINATE ______ mg IV ____________________

***PO administration or slow infusion via IVPB are preferred for metoclopramide to reduce the risk of akathisia. Suggest 5 mg for mild/moderate nausea or if CrCl less than 40mL/min; 10 mg for moderate/severe nausea, and CrCl over 40mL/min*

☐ metoclopramide 10 mg PO once
☐ metoclopramide 5 to 10 mg PO every 6 hour PRN for nausea/vomiting
☐ metoclopramide ______ mg PO ____________________

☐ metoclopramide 10 mg IVPB once
☐ metoclopramide 5 to 10 mg IVPB every 6 hour PRN for nausea/vomiting
☐ metoclopramide ______ mg IVPB ____________________

***4 mg starting dose recommended for IV ondansetron*

☐ ondansetron 4 mg IV once
☐ ondansetron 4 mg IV to be repeated once 30 minutes after first dose PRN for nausea/vomiting
☐ ondansetron 4 mg IV every 8 hour PRN for nausea/vomiting
☐ ondansetron ______ mg IV ____________________

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Medications continued

Antiemetics continued

☐ ondansetron tab 8 mg PO every 8 hour PRN for nausea/vomiting
☐ ondansetron tab ______ mg PO __________________

***Due to high cost, recommend reserving ondansetron DISINTEGRATING tab for actively vomiting patients without an IV*

☐ ondansetron DISINTEGRATING tab 8 mg PO every 8 hour PRN for nausea/vomiting
☐ ondansetron DISINTEGRATING tab ______ mg PO __________________

Non-opiate - Oral

Suggest 325 mg to 650 mg for mild to moderate pain, 975 mg to 1000 mg for moderate to severe pain

☐ acetaminophen 975 mg OR 1000 mg PO once
☐ acetaminophen 325 mg to 1000 mg PO every 4 hours PRN for pain (maximum 3000 mg/day)
☐ acetaminophen tab ______ mg PO __________________ (maximum 3000 mg/day)

Opiate Oral

Maximum dosage of acetaminophen from all sources not to exceed 3000 mg per day

☐ acetaminophen 325 mg/caffeine 15 mg/codeine 30 mg 2 tabs PO once
☐ acetaminophen 325 mg/caffeine 15 mg/codeine 30 mg 1 to 2 tabs PO every 4 hours PRN for pain
☐ acetaminophen 325 mg/caffeine 15 mg/codeine 30 mg ______ tabs PO every ______ hours PRN for pain

☐ oxyCODONE 5 mg/acetaminophen 325 mg 2 tabs PO once
☐ oxyCODONE 5 mg/acetaminophen 325 mg 1 to 2 tabs PO every 4 hours PRN for pain
☐ oxyCODONE 5 mg/acetaminophen 325 mg ______ tabs PO every ______ hours PRN for pain

Suggest 1 mg for moderate pain and 2 mg for severe pain

☐ HYDROmorphone 1 mg PO once
☐ HYDROmorphone 1 to 2 mg PO every 4 hours PRN for pain
☐ HYDROmorphone ______ mg PO every ______ hours PRN for pain

Opiates - Parenteral

Suggest 0.5 mg for moderate pain and 1 mg for severe pain

☐ HYDROmorphone 1 mg IV once
☐ HYDROmorphone 0.5 to 1 mg IV every 10 minutes PRN for pain (maximum 3 mg total)
☐ HYDROmorphone ______ mg IV every ______ minutes PRN for pain

Suggest 2.5 mg for moderate pain and 5 mg for severe pain

☐ morphine 5 mg IV once
☐ morphine 2.5 to 5 mg IV every 10 minutes PRN for pain (maximum 15 mg total)
☐ morphine ______ mg IV every ______ minutes PRN for pain

Suggest 25 mcg for moderate pain and 50 mcg for severe pain

☐ fentaNYL 50 micrograms IV once
☐ fentaNYL 25 to 50 micrograms IV every 5 minutes PRN for pain (maximum 200 micrograms total)
☐ fentaNYL ______ micrograms IV every ______ minutes PRN for pain

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Other Medications

- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

Consults

- ☐ Consult Neurosurgery
- ☐ Consult nearest appropriate ED to arrange for CT scan via RAAPID
- ☐ Consult ____________________

Prescriber Signature	Date *(dd-Mon-yyyy)*	Time *(hh:mm)*