



# THORACENTESIS/PARACENTESIS CHECKLIST

PATIENT NAME:

DOB:

PROCEDURE:

PROCEDURE DATE:

SPOKE TO:

CONTACT #:

### NEW PATIENT:

#### ORDERS

(ORDER FOR THORA MUST SAY "THORA WITH CHEST XRAY")

- H & P
- DEMOGRAPHICS
- INSURANCE
- MEDS LIST
- DOES REFERRING WANT FLUIDS TESTED

#### BLOOD THINNERS:

- ASPIRIN \_\_\_\_\_ MG
- PLAVIX/COUMADIN/WARFARIN \_\_\_\_\_ MG
- IBUPROFEN/MOTRIN/ADVIL

**DC DATE:** \_\_\_\_\_ **LAB DATE:** \_\_\_\_\_

LABS: (CBC, PT, PTT)

WHERE ORDERED:

SENT TO:

- LIGHT BREAKFAST, TAKE MEDICATIONS
- PATIENT SPEAKS ENGLISH: YES/NO IF NO, PERSON TO ACCOMPANY: \_\_\_\_\_

### RECURRENT PATIENT:

- LABS EVERY 30 DAYS: (CBC, PT, PTT)
- STANDING ORDER IN CHART (WILL BE RENEWED ONCE PER MONTH)

**THORACENTESIS WILL GET CHEST X-RAY FOLLOWING PROCEDURE**