1. Assure patient is securely intubated.

2. Assure patient is on routine (not prn) sedation/analgesia. If not call house officer.

3. Establish PNS threshold per protocol. Use ulnar site. If unsuccessful, try facial nerve. If still unsuccessful, call House officer. If patient is currently chemically paralyzed, set output at 50ma/.

(Select only one medication, if more than one is selected pharmacy will only enter the first one selected)

4. Loading Dose
   - Pancuronium ____________ mg (usual 0.1mg/kg)
   - Vecuronium ____________ mg (usual 0.1mg/kg)
   - Cis-Atracurium ____________ mg (usual 0.1mg/kg)

(Select only one medication, if more than one is selected pharmacy will only enter the first one selected)

5. Maintainence Infusion
   - Pancuronium ____________ mg/kg/hr
   - Vecuronium ____________ mg/kg/hr
   - Cis-Atracurium ____________ mg/kg/hr

6. Check pupils q 1 hour until infusion rate has not change for 4 hours, then q 2 hours.

7. Test Train of Four (TOF) q 1 hour until infusion rate has not changed for 4 hours, then q 2 hours.
   - 0/4 Twitches: Confirm lead placement, Hold infusion until 1/4 twitches return, then restart infusion with rate decreased by 25%, recheck in 1 hour.
   - 1/4 Twitches: Decrease infusion rate by 10%, recheck in 1 hour.
   - 2/4 Twitches: Continue present infusion rate.
   - 3/4 Twitches: Increase infusion rate by 10%, recheck in 1 hour
   - 4/4 Twitches: Increase infusion rate by 25%, recheck in 1 hour.
   - Patient movement compromising clinical status (i.e. ventilator asynchrony or increased ICP): Rebolus with loading dose in #4 above. Increase infusion rate by 25%, recheck in 1 hour.

8. Lacrilube each eye q 6 hours and prn.

9. Documentation:
   a) Record drug name and infusion rate in mg/kg/hr in space about graphic vital signs.
   b) Record TOF response as # of twitches/4 (for ex. 2/4) in blank boxes below graphic vital signs.
   c) Record NMB infusion as any other IV fluid on I & O sheet.

☐ TO  ☐ Read back
Order taken by Signature: _______________________________ Date/Time: _______________________________

Physician Signature_____________________________ Date/Time _______________________________