

✓	CARDIOVASCULAR DEVICE IMPLANTATION PRE-PROCEDURE ORDERS	ROOM NO. _____
ALLERGIES: _____		HT _____ (Cm) WT _____ (Kg)
<p>A <input checked="" type="checkbox"/> indicates a selected order. If a defaulted order is not appropriate, draw a line through the order.</p> <p>Device Consent (✓ check all that apply):</p> <p>Sedation: <input checked="" type="checkbox"/> Moderate sedation and analgesia</p> <p>Devices (Choose appropriate): <input type="checkbox"/> Insertion of: <input type="checkbox"/> _____ chamber Permanent Pacemaker <input type="checkbox"/> Automatic Implantable Cardiac Defibrillator <input type="checkbox"/> Bi-Ventricular Pacemaker <input type="checkbox"/> Implantable Cardiac Defibrillator <input type="checkbox"/> Temporary Loop Recorder by _____ M.D.</p> <p><input type="checkbox"/> Generator Replacement by: _____ M.D.</p> <p><input type="checkbox"/> Lead <input type="checkbox"/> Replacement <input type="checkbox"/> Revision and/or <input type="checkbox"/> Extraction by _____ M.D. Lead type: Pacemaker <input type="checkbox"/> Bi-Ventricular Pacemaker <input type="checkbox"/> Implantable Cardiac Defibrillator Lead</p> <p><input type="checkbox"/> Other _____ by: _____ M.D.</p> <p>Diagnosis: _____</p> <p>Isolation (check all that apply): <input type="checkbox"/> Airborne precautions <input type="checkbox"/> Contact precautions <input type="checkbox"/> Droplet precautions</p> <p>Nursing: <input checked="" type="checkbox"/> Skin clip and prep _____ (location). (Outpatient only) <input checked="" type="checkbox"/> Provide pre-procedural education <input checked="" type="checkbox"/> Have patient void on-call to procedure <input checked="" type="checkbox"/> If patient is diabetic, check capillary blood glucose upon arrival to Pre-Op Department <input type="checkbox"/> Place urinary catheter; Reason for placement: Procedural. For inpatient admission, upon placement, send urine for UA to Reflex to Culture (UATC) <input type="checkbox"/> Other: _____</p> <p>Nutrition: <input checked="" type="checkbox"/> NPO <input type="checkbox"/> after midnight <input type="checkbox"/> 6 hours pre-procedure <input type="checkbox"/> except PO meds</p> <p>LAB: <input type="checkbox"/> Pre-procedural labs to be done at _____ including: <input type="checkbox"/> BMP <input type="checkbox"/> CBC <input type="checkbox"/> HCGS <input type="checkbox"/> Lipid Profile <input type="checkbox"/> Hepatic Function Panel <input type="checkbox"/> APTT <input type="checkbox"/> PT</p> <p>Procedures: <input type="checkbox"/> 12-lead EKG at _____ to be done at _____; Reason for exam: _____</p> <p>IV Fluids: <input type="checkbox"/> _____ to run at _____ mL / hour. Start at _____ <input type="checkbox"/> Saline lock, flush per protocol</p> <p>12-hour Chart Check _____ RN DATE: ____ / ____ / ____ TIME: _____</p> <p>T.O. _____ Taken by: _____ / ____ / ____, TIME: _____</p> <p>TRANSCRIBED BY: _____ / ____ / ____, TIME: _____ NOTED BY: _____ / ____ / ____, TIME: _____</p> <p>PHYSICIAN SIGNATURE: _____ DATE: _____ TIME: _____</p> <p>PRINTED NAME/ID#: _____ (COUNTER-SIGN ALL T.O. ORDERS WITHIN 48 HOURS, AND INCLUDE THE DATE/TIME AUTHENTICATED)</p>		



**CARDIOVASCULAR DEVICE IMPLANTATION
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PATIENT ID _____

