


✓	ELECTROPHYSIOLOGY STUDY 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:</p> <p><input checked="" type="checkbox"/> Moderate sedation and analgesia</p> <p>Electrophysiology (Choose appropriate):</p> <p><input type="checkbox"/> Electrophysiology Study with <input type="checkbox"/> Atrial Fibrillation Ablation <input type="checkbox"/> Atrial Flutter Ablation <input type="checkbox"/> Supraventricular Tachycardia Ablation <input type="checkbox"/> Ventricular Tachycardia Ablation <input type="checkbox"/> AV Node Ablation by _____ M.D.</p> <p><input type="checkbox"/> Non-Invasive Electrophysiology Study by: _____ M.D.</p> <p><input type="checkbox"/> Other _____ by: _____ M.D.</p> <p>Diagnosis: _____</p> <p>Code Status: For DNAR status complete separate DNAR Physician Orderset</p> <p>Isolation (check all that apply):</p> <p><input type="checkbox"/> Airborne precautions <input type="checkbox"/> Contact precautions <input type="checkbox"/> Droplet precautions</p> <p>Nursing:</p> <p><input checked="" type="checkbox"/> Skin clip and prep _____ (location). (Outpatient only)</p> <p><input checked="" type="checkbox"/> Provide pre-procedural education</p> <p><input checked="" type="checkbox"/> Have patient void on-call to procedure</p> <p><input checked="" type="checkbox"/> If patient is diabetic, check capillary blood glucose upon arrival to Pre-Op Department</p> <p><input type="checkbox"/> Place urinary catheter; Reason for placement: <u>Procedural</u></p> <p><input type="checkbox"/> Other: _____</p> <p>Nutrition:</p> <p><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>Procedures:</p> <p><input type="checkbox"/> 12-lead EKG at _____ to be done at _____ ; Reason for exam: _____</p> <p>LAB:</p> <p><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>IV Fluids:</p> <p><input type="checkbox"/> _____ to run at _____ mL/hour. Start at _____</p> <p><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#: _____</p>		
		(COUNTER-SIGN ALL T.O. ORDERS WITHIN 48 HOURS, AND INCLUDE THE DATE/TIME AUTHENTICATED)
 <p>St. Joseph Hospital ST. JOSEPH HEALTH SYSTEM</p> <p>ELECTROPHYSIOLOGY STUDY PRE-PROCEDURE ORDERS</p>		PATIENT ID _____

✓	ELECTROPHYSIOLOGY STUDY PRE-PROCEDURE ORDERS	ROOM NO. _____
ALLERGIES: _____		HT _____ (Cm) WT _____ (Kg)
Medications:		
<input type="checkbox"/> Give <u>all</u> medications the day of the procedure except the following: _____		
Medications on-call to Cath Lab (after all consents signed):		
<input type="checkbox"/> Diazepam (Valium) _____ mg Po x1 on-call to Cath lab, or		
<input type="checkbox"/> Lorazepam (Ativan) _____ mg Po x 1 on-call to Cath lab		
<input type="checkbox"/> Diphenhydramine (Benadryl) _____ mg Po x 1 on-call to Cath lab		
Additional Orders:		
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		
DRAFT		
12-hour Chart Check _____ RN		DATE: ____ / ____ / ____ TIME: _____
T.O. _____ Taken by: _____		____ / ____ / ____, TIME: _____
TRANSCRIBED BY: _____		____ / ____ / ____, TIME: _____ NOTED BY: _____
____ / ____ / ____, TIME: _____		____ / ____ / ____, TIME: _____
PHYSICIAN SIGNATURE: _____		DATE: _____ TIME: _____
PRINTED NAME/ID#: _____		(COUNTER-SIGN ALL T.O. ORDERS WITHIN 48 HOURS, AND INCLUDE THE DATE/TIME AUTHENTICATED)



**ELECTROPHYSIOLOGY STUDY
PRE-PROCEDURE ORDERS**

PATIENT ID _____