

✓	<b>CARDIAC CATHETERIZATION/PCI POST-PROCEDURE ORDERS</b>	ROOM NO. _____
<b>ALLERGIES:</b> _____		HT _____ (Cm)    WT _____ (Kg)
<p><b>A <input checked="" type="checkbox"/> indicates a selected order. If a defaulted order is not appropriate, draw a line through the order.</b></p> <p><b>Admission Status: <i>Must select one when patient is first admitted. Do NOT use to convert a patient's admission status.</i></b></p> <p><input type="checkbox"/> <b>Out-Patient Surgery / Procedure with or without Out-Patient Recovery (SDC).</b> (e.g. expected post-procedure recovery, pain management.)</p> <p><input type="checkbox"/> <b>Admit to Medical Observation (INo).</b> Observation is an outpatient status used to determine the need for further treatment or possible inpatient admission. Usually can be determined in less than 24 hours. Patient must meet observation criteria each hour.</p> <p><input type="checkbox"/> <b>Admit to Inpatient. Preferred unit:</b> _____</p> <p><b>Diagnosis:</b> _____</p> <p><b>Code Status: For DNAR status complete separate DNAR Physician Orderset</b></p> <p><b>Isolation (check all that apply):</b></p> <p><input type="checkbox"/> Airborne precautions</p> <p><input type="checkbox"/> Contact precautions</p> <p><input type="checkbox"/> Droplet precautions</p> <p><b>Vital Signs &amp; Call Orders:</b></p> <p><input checked="" type="checkbox"/> Vital signs every 15 minutes X 1 hour, then Q 30 minutes X 2, then per unit protocol</p> <p><input type="checkbox"/> Other _____</p> <p><b>Nursing:</b></p> <p><input checked="" type="checkbox"/> Assess and document arterial site and distal peripheral pulses every 15 minutes until sheath removed and until 1 hour post removal, then every 30 minutes X 6, then routine</p> <p><input type="checkbox"/> Activated Clotting Time (ACT) at _____</p> <p><input type="checkbox"/> Pre-medicate 5 minutes prior to sheath removal – see medications</p> <p><input type="checkbox"/> If arterial / venous sheaths in place, DC sheaths when Activated Clotting Time (ACT) is less than or equal to _____ or APTT is less than or equal to _____. If there is bleeding at the puncture site(s), apply handheld pressure for 20 minutes and notify the Cardiologist</p> <p><input checked="" type="checkbox"/> Cardiac monitoring</p> <p><input type="checkbox"/> May go to / from procedure without cardiac monitoring</p> <p><input checked="" type="checkbox"/> Order Cardiac Rehab Phase II – Fax copy of this order to Cardiac Rehab Department (ext: 18755)</p> <p><input type="checkbox"/> If hemodynamically stable, with no signs / symptoms of bleeding or hematoma, and meets discharge criteria, may discharge home at _____</p> <p><b>Activity:</b></p> <p><input type="checkbox"/> HOB flat until _____, then up at 30 degrees</p> <p><input type="checkbox"/> Bed rest with affected leg straight X _____ hours post-sheath removal, then ambulate 50 feet</p> <p><input type="checkbox"/> Up ad lib at _____</p> <p><b>12-hour Chart Check</b> _____ <b>RN</b>    <b>DATE:</b> ____ / ____ / ____    <b>TIME:</b> _____</p> <p><b>T.O.</b> _____ <b>Taken by:</b> _____ / ____ / ____, <b>TIME:</b> _____</p> <p><b>TRANSCRIBED BY:</b> _____ / ____ / ____, <b>TIME:</b> _____    <b>NOTED BY:</b> _____ / ____ / ____, <b>TIME:</b> _____</p> <p><b>PHYSICIAN SIGNATURE:</b> _____ <b>DATE:</b> _____ <b>TIME:</b> _____</p> <p><b>PRINTED NAME/ID#:</b> _____ (COUNTER-SIGN ALL T.O. ORDERS WITHIN 48 HOURS, AND INCLUDE THE DATE/TIME AUTHENTICATED)</p>		



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<b>ALLERGIES:</b>		HT _____ (Cm)    WT _____ (Kg)
<b>Nutrition:</b>		
<input type="checkbox"/> Cardiac <input type="checkbox"/> Cardiac 2 Gm sodium <input type="checkbox"/> Cardiac 2 Gm sodium / Diabetic Carb Control _____ calories <input type="checkbox"/> Other _____  <input type="checkbox"/> Nutrition Consult _____ Reason for consult: _____		
<b>LAB:</b>		
<input type="checkbox"/> BMP at _____ <input type="checkbox"/> CBC at _____ <input type="checkbox"/> CKMB at _____ <input type="checkbox"/> Lipid Profile at _____ <input type="checkbox"/> PT at _____ <input type="checkbox"/> APTT at _____ <input type="checkbox"/> Troponin I at _____ <input type="checkbox"/> Other _____		
<b>Procedures:</b>		
<input type="checkbox"/> 12-lead EKG on arrival to department; Reason for exam: _____ <input type="checkbox"/> 12-lead EKG in am; Reason for exam: _____ <input type="checkbox"/> Echocardiogram (ECHOA) in am; Reason for exam: _____		
<b>IV Fluids:</b>		
<input type="checkbox"/> _____ to run at _____ mL / hour X _____ hours <input type="checkbox"/> DC IV Fluids at _____ & convert to saline lock and flush per protocol <input type="checkbox"/> Saline lock, flush per protocol		
<b>Medications:</b>		
<b>Analgesics</b>		
<input type="checkbox"/> Acetaminophen (Tylenol) 650 mg PO Q 6 hours PRN headache or mild pain (scale 1-3). Total acetaminophen not to exceed 4000 mg / 24 hours) <input type="checkbox"/> Norco 5-325 1 Tab PO Q 4 hours PRN moderate pain (scale 4-6). If ineffective, may give an additional Tablet in 1 hour, then may give 2 Tabs Po Q 4 hours PRN moderate pain thereafter. (Do not exceed 12 Tabs / 24 hours or total acetaminophen not to exceed 4000 mg / 24 hours).		
<b>Anti-emetics</b>		
<input type="checkbox"/> Ondansetron (Zofran) 4 mg IVP Q 12 hours PRN nausea / vomiting. May give IM if no IV access. If ineffective, give Prochlorperazine (Compazine) 10 mg IV Q 6 hours PRN nausea / vomiting. May give IM if no IV access		
<b>Hypnotics</b>		
<input type="checkbox"/> Zolpidem (Ambien) 10 mg PO at bedtime PRN sleep. If patient is greater than 65 years, give Zolpidem (Ambien) 5 mg PO at bedtime PRN sleep		
<b>12-hour Chart Check</b> _____		<b>RN</b> _____ <b>DATE:</b> ____ / ____ / ____ <b>TIME:</b> _____
T.O. _____		<b>Taken by:</b> _____ <b>TIME:</b> _____
<b>TRANSCRIBED BY:</b> _____ <b>TIME:</b> _____		<b>NOTED BY:</b> _____ <b>TIME:</b> _____
<b>PHYSICIAN SIGNATURE:</b> _____		<b>DATE:</b> _____ <b>TIME:</b> _____
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<b>ALLERGIES:</b>		HT _____ (Cm)    WT _____ (Kg)
<b>Cardiac Medications:</b>		
<input type="checkbox"/> Aspirin enteric coated _____ mg PO daily (First dose to be given within 24 hours of arrival time. If not, please indicate reason withheld) _____		
<input type="checkbox"/> Clopidogrel (Plavix) _____ mg PO X 1 loading dose now. Give on arrival in unit if not done in cath lab, then 75 mg PO daily		
<input type="checkbox"/> Antihyperlipidemia agent: _____		
<input type="checkbox"/> ACE Inhibitor / ARB: _____ (if not, indicate reason withheld) _____		
<input type="checkbox"/> Beta Blocker: _____ (First dose to be given within 24 hours of arrival time. If not, please indicate why?) _____		
<input type="checkbox"/> Nitroglycerin (25 mg / 250 mL) IV infusion at _____ mCg / min. May titrate to _____ mCg / min PRN chest pain or for SBP greater than or equal to _____		
<input type="checkbox"/> Eptifibatide (Integrilin) (75 mg / 100 mL) IV infusion at _____ mCg / kg / min X _____ hours. Dose should be reduced in patients with a CrCl less than 50 mL / min		
<input type="checkbox"/> Heparin (25,000 units / 250 mL) IV infusion at _____ units / hour X _____ hours. Goal APTT = _____ Indication for heparin: _____		
<input type="checkbox"/> Check here for Pharmacy to dose per hospital protocol		
<b>Pre-medications Prior to Sheath Removal:</b>		
<input type="checkbox"/> Morphine Sulfate 2 mg IV Push X 1 dose, to be given 5 minutes prior to sheath removal, <b>or</b>		
<input type="checkbox"/> Hydromorphone (Dilaudid) 0.5 mg IV Push X 1 dose, to be given 5 minutes prior to sheath removal		
<b>Additional Orders:</b>		
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		
DRAFT		
<b>12-hour Chart Check</b> _____ <b>RN</b> <b>DATE:</b> _____ / _____ / _____ <b>TIME:</b> _____		
T.O. _____ <b>Taken by:</b> _____ / _____ / _____, <b>TIME:</b> _____		
TRANSCRIBED BY: _____ / _____ / _____, <b>TIME:</b> _____ <b>NOTED BY:</b> _____ / _____ / _____, <b>TIME:</b> _____		
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