



CULLMAN
REGIONAL

PHYSICIAN'S ORDERS

NAME:
ROOM NO:
(ADDRESS)
HOSP. NO.
PHYSICIAN

Another brand of drug identical in form and content may be dispensed unless checked. ☐

Inpatient Pre-Heart Catheterization Order Set

- NPO, **except for medications**, after 2200, or after full liquid breakfast if case is to be done after 12:00 Noon (**includes ALL tube feedings**)
- ☐ Permit: Left and Right Heart Catheterization, Selective Coronary Arteriography and Left Ventriculogram.
- ☐ Permit: Left and Right Heart Catheterization, Selective Coronary Arteriography and Left Ventriculogram with Possible Coronary Angioplasty with or without Stent Placement.
- ☐ Permit for Other: _____
- Clip hair from bilateral groins from umbilicus to mid-thigh using electric clippers.
- Sign release and obtain PTCA/CABG records and place on chart prior to catheterization
- Notify Cardiovascular of ordered procedure(s)
- IV of NS at KVO ml/hr on call to cath lab
- ☐ Sodium Bicarbonate Drip per infusion order set for Creatinine > 1.5
- EKG, if not already done
- CXR 2 views (if over 40 yrs old or if not done within last 3 months)
- LABS:**
 - Blood glucose performed day of the procedure on all diabetics. (FSBS or lab drawn)
 - CMP, CBCcAD; if not done within 1 week. **Notify MD if abnormal.**
 - P.T. if on Coumadin. **Notify primary MD or ordering physician for INR > 1.4**
- MEDS:**
 - Hold Coumadin 72 hours prior to Cath or as ordered by MD.
 - Hold Lovenox morning of Cath or 12 hours prior to Cath.
 - Hold Xarelto/Eliquis for 24 hours prior to Cath/PCI.
 - For Dr. Mahan and Dr. Papapietro: Hold Metformin 12-24 hours prior to cath.
 - Cardiovascular Nursing Staff to **STOP Heparin Drip and/or Integrilin infusion prior to procedure unless otherwise ordered per MD.**
 - If allergic to IV contrast dye notify ordering physician for pre-medication
 - On call medication for Dr. Lee only: Valium 10 mg Po; Benadryl 25 mg Po; Pepcid 20 mg Po
 - Reversal agents (narcan, romazicon), available in cath lab medication pyxis, to be given per MD orders.

MD Signature: _____ Date & Time: _____

• Required ☐ Optional

Cullman Regional

Please use Ball Point Pen ONLY

Physician's Orders

DO NOT USE: U IU QD QOD MS MSO4 MgSO4

Revised & approved

by Director of Cardiovascular Services: 07/30/19 Page 1 of 1



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Post Heart Catheterization Order Set

- ☐ Admit: ☐ Admit Inpatient ☐ Place in Observation Services ☐ Outpatient
- ☐ Bedrest x ___ hours. Flat in bed x ___ hours. HOB elevated 30 degrees x ___ hours. Up in chair x ___ hours.
- After bed rest, may be up to BR with assistance.
- ☐ May roll side to side with catheterized leg straight in _____ hours.
- ☐ IVF: NS @ _____ ml/hr x _____ hours then _____, or ☐ saline lock.
- ☐ IVF: _____ @ _____ ml/hr x _____ hours, then IVF _____ @ _____ ml/hr or ☐ saline lock
- ☐ Continue Sodium Bicarb per infusion order set or ☐ @ _____ ml/hr, then ☐ IVF _____ @ _____ ml/hr or ☐ saline lock.
- Record BP, HR, pulse distal to cath site, and observe cath site, q 15 minutes x 4, q 30 minutes x 4, q 1 hour x 4, then q 4 hour until discharge.
 - Notify Cardiologist or Primary Care Physician if:
 - a. Bleeding or swelling noted at site.
 - b. No distal pulse is present.
 - c. Systolic BP is less than 90 or greater than 180.
 - d. Chest Pain, SOB, pain at cath site, or numbness in extremity develops.
 - Telemetry x 4 hours, then discontinue if stable or otherwise ordered.
 - Remove dressing in am. If pressure dressing in place, remove prior to ambulating.
 - Review Discharge Instructions Sheet with patient.
 - Resume prior diet when tolerating liquids.
 - Straight cath PRN if unable to void.

LABS:

- Creatinine post Percutaneous Coronary Intervention; notify MD if abnormal.

MEDS:

- **Hold Metformin compounds x 48 hours post procedure, then resume.**
- Dilaudid 1 mg IV q 1 hour PRN for back pain. Discontinue 6 hours post catheterization.
- Zofran 4 mg IV q 4 hours PRN for nausea.

FINDINGS:

- ☐ No atherosclerotic coronary artery disease.
- ☐ Atherosclerotic coronary artery disease
- ☐ Acute coronary ischemia (concluded as probable cause of symptoms requiring cath)
- ☐ Noncardiac chest pain
- ☐ Ambulate in 4 hours ☐ Discharge if groin ok

MD Signature: _____ **Date & Time:** _____

• Required ☐ Optional

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Physician's Orders

DO NOT USE:

U IU QD QOD MS MSO4 MgSO4



Informed Consent for Cardiovascular Procedures Performed in the Cath Lab

Patient Addressograph

Date: _____ Time: _____

1. I authorize the performance upon (name) _____ the following procedure:

_____ to be performed under the direction of Dr. _____.

2. I consent to the performance of cardiovascular procedures in addition to, or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor or his associates or assistants may consider necessary or advisable in the course of the procedure.
3. The nature and purpose of the procedure, possible alternative methods of treatments, the risks involved, and the possibility of complications have been explained to me. No guarantee or assurance has been given as to the results that may be obtained. I have had an opportunity to ask questions and have these questions answered.
4. I consent to the administration of such anesthetics/conscious sedation as may be considered necessary or advisable by the physician responsible for the service. The nature and purpose of the anesthetic, possible alternatives, risks involved, and the possibility of complications have been explained to me. I have been educated as to the risks, benefits, and possible outcomes.
5. I consent to the administration of blood and/or any blood components as may be considered necessary or advisable. The risks and benefits of blood transfusions have been explained to me.
6. I consent to the disposal by hospital authorities of any tissues or parts/products of conception which may be removed.
7. I consent to the withdrawal of a blood sample of test for antibodies, including, but not limited to HIV (AIDS) and Hepatitis B. I understand that the blood test(s) will be done only if an employee or physician has had an accidental needle stick or mucous membrane exposure to my blood and body fluid. I understand that the results of any testing will be kept strictly confidential and released to my surgeon. I understand that these tests will be done at no cost to me. All of my questions have been answered.
8. In the interest of education and research, I authorize the taking of photographs, movies, or videotapes of the authorized procedure or medical service. I understand that the following surgery, the photographs will be maintained on my permanent medical record. Any movies or video tapes will be given to my surgeon.
9. I authorize representatives of the company supplying any equipment, prosthetic device, or other device which may be used during my procedure to be present and observe the authorized procedure.
10. I understand that from time to time there may be nursing students, medical students, or other students present in the operating room. I give my permission for these individuals to be present.
11. I understand Cullman Regional Medical Center does not offer open heart surgery procedures. It has been explained to me that if I wish to have my cardiac diagnostic or interventional procedure performed at a hospital with cardiac surgery services, my physician and medical staff will make efforts to transfer me to a medical facility of my choice.
12. **CONSENT TO CHANGE IN STATUS DO NOT RESUSCITATE:** I, _____ (patient name), acknowledge the "Do Not Resuscitate Policy" of the Cardiac/Vascular Department. I agree to suspend the DNR status while the procedure is being performed. In the event of Cardio-Pulmonary arrest during the performance of the procedure, resuscitation efforts will be initiated and maintained at the discretion of the attending Physician. These procedures may include, but are not limited to, Cardiac/Vascular Catheterization, with or without Interventions, Cardioversion, Transesophageal Echocardiogram, Pacemaker/Defibrillator procedures, Loop Recorder and Internal Cardiac Defibrillator.
13. I have been advised not to drive a motor vehicle, operate machinery, consume alcoholic beverages, sign legal documents, or take medications other than those prescribed by my doctor, for 24 hours following administration of general anesthesia or sedation. Also, I have been advised to have a responsible adult with me for at least 24 hours after my procedure.
14. I certify that I have been instructed not to eat or drink anything, including water, after midnight/_____, or that my child will not eat or drink after midnight/2:00 a.m. ☐ **Not applicable.**
15. Other/Exceptions, if any: ☐ **Not applicable** _____

Witness:

Authorizing Signatures:

This form has been fully explained to me and I certify that I understand its contents. By my signature below, I consent to all of the above.

(Signature) _____

- (1) Patient _____
- (2) Person authorized to sign for patient _____
- **Are you the designated decision maker?** ☐ **Yes**
- (3) Authority to consent _____

PHYSICIAN STATEMENT

Prior to this procedure, I discussed with the patient/guardian reasonable expectations regarding a beneficial outcome and alternative treatments. We also discussed the general and necessary risks and complications of the procedure and the possible need for and the risk of blood and blood products and available alternatives. The patient/guardian/family member has had all questions answered pertaining to this procedure. As a result, I believe that the patient/guardian/family member understands the general necessary risks and potential benefits of this treatment and available alternatives and agrees to services.

Physician Signature: _____

Date & Time: _____



Time Out

Date Performed: _____ Time Performed: _____

Elements Completed:

- ☐ All pause
- ☐ Introduction of all personnel involved
- ☐ Correct patient
- ☐ Correct procedure
- ☐ Accurate procedure consent form
- ☐ Correct position
- ☐ Site marked by provider ☐ N/A
- ☐ Site marked by provider is visible after patient is draped ☐ N/A
- ☐ Relevant images/equipment and results labeled and displayed ☐ N/A
- ☐ Antibiotics or fluids for irrigation ☐ N/A
- ☐ Safety precautions based on patient history or medication use
- ☐ Each team member verbalizes agreement

Participants in Time Out:

Nurse's Signature: _____

For Additional Procedure Timeouts – Elements Completed

Date Performed: _____ Time Performed: _____

- ☐ All pause
- ☐ Introduction of all personnel involved
- ☐ Correct patient
- ☐ Correct procedure
- ☐ Accurate procedure consent form
- ☐ Correct position
- ☐ Site marked by provider ☐ N/A
- ☐ Site marked by provider is visible after patient is draped ☐ N/A
- ☐ Relevant images/equipment and results labeled and displayed ☐ N/A
- ☐ Antibiotics or fluids for irrigation ☐ N/A
- ☐ Safety precautions based on patient history or medication use
- ☐ Each team member verbalizes agreement

Participants in Time Out:

Nurse's Signature: _____



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