PHYSICIAN'S ORDERS

CULLMAN REGIONAL

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

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

Outpatient Pre-Pacemaker/Defibrillator Order Set
Dr. Varquez

- Outpatient admission to Dr. Mir Varquez, change to observation if admission requires longer than 6 hours and continue previous orders.
- Diagnosis:
- Allergies:
- NPO after 2200 day before procedure if am case, or after full liquid breakfast if case is to be done after 12:00 noon **(includes ALL tube feedings)**.
- Routine vital signs
- Activities as tolerated
- Clip hair from bilateral upper chest prior to transport to Cardiovascular Services. Hair should be clipped with electric clippers.
- Obtain permit to be performed by Dr. Varquez for:
  - ❑ Permanent Pacemaker Implantation ❑ Atrial ❑ Ventricular ❑ AV _____
  - ❑ Internal Cardiac defibrillator Implantation _____
  - ❑ Generator Replacement ❑ Single ❑ Dual ❑ Upgrade to dual ❑ Internal Cardiac Defibrillator _____
  - ❑ Lead Wire Revision _____
  - ❑ Lead Wire Replacement ❑ Single ❑ Dual ❑ Upgrade to dual _____
  - ❑ Pacemaker Pocket Revision
- Obtain H&P from performing MD or Primary Care Physician requesting procedure, and place on chart prior to procedure.
- Normal saline @30 ml/hr; please start IV in non-dominant upper extremity. Prep both sides of the chest.
- Chest x-ray
- 12 Lead EKG
- CMP, CBC with auto Diff, Protime, PTT; notify MD of abnormal results.
- **Ancef** one gram IVPB on call to Cath Lab; if allergic to Ancef, give Clindamycin 600 mg IVPB on call to cath lab.
- Hold am insulin and oral hypoglycemic until after procedure.
- **To be used for irrigation – send to Cath Lab with patient:**
  Mix one liter of sterile water with:
  - Neomycin 40 mg base
  - Polymycin B sulfate 200,000 units
  - Bacitracin 200,000 units (4 vials of 50,000 units each)

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

Please use Ball Point Pen ONLY

DO NOT USE: U IU QD QOD MS MSO4 MgSO4

• **Required** ❑ **Optional**

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Post Pacemaker Standing Order Set
Dr.Varquez

❑ Admit ❑ Admit Inpatient ❑ Place in Observation Services ❑ Outpatient

- Vital signs and neurovascular checks: Observe for bleeding or hematoma formation at incision site/catheter insertion site. Assess pedal pulses when applicable. Every 15 minutes x 4 times, q 30 minutes x 4 times, q 1 hour x 4 times.
- Strict bedrest x 1 hour, then up to bathroom with assistance.
- Do NOT allow patient to turn to operative site.
- Elevate HOB as tolerated
- Do not allow patient to raise arm on affected side above shoulder level.
- Keep incision DRY x 10 days.
- Telemetry monitor, place leads on back away from incision site.
- Resume pre-procedure diet as tolerated.
- Notify ❑ Dr. Varquez ❑ _____ for:
  Heart rate less than _____beats per minute or greater than _____beats per minute.
  SBP less than _____ or greater than _____.
  If patient is unable to void.
- AP CXR Now ❑ Portable.

❑ AP and Lateral CXR ❑ Now ❑ 5:00 am

❑ Reglan 10 mg IV q 6 hours PRN nausea/vomiting x 48 hours not relieved by Zofran.

❑ MagAl Plus 30 ml Po q 6 hours PRN indigestion.

❑ Tylenol 650 mg Po q 4 hours PRN pain, maximum dose not to exceed 4000 mg

❑ Zofran 4 mg IV q 2 hours PRN nausea/vomiting x 48 hours

❑ Norco 7.5 mg ❑ 1 tab for moderate pain ❑ 2 tab for severe pain Po q 6 hours PRN pain.

❑ **Vancomycin** ❑ 500 mg ❑ 0.75 gm ❑ 1 gm ❑ 1.5 gm IV x 1 dose 12 hours after pre-procedure dose. (Given @ _____)

❑ **Cefazolin** ❑ 1 gm ❑ 1.5 gm IV q 8 hours x 2 doses post op **ONLY**, begin 8 hours after pre-procedure dose. (Given @ _____)

❑ **Clindamycin** 600 mg IV q 6 hours x 2 doses post op ONLY, begin 6 hours after pre-procedure dose. (Given @ _____)

● Required ❑ Optional

MD Signature: _____ Date & Time:_____

Please use Ball Point Pen ONLY

Revised: 04/18/18 **DO NOT USE: U IU QD QOD MS MSO4 MgSO4**

● Required ❑ Optional

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:

_____
(Signature)

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.

(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: _____

CULLMAN REGIONAL

Patient Label

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:

_____

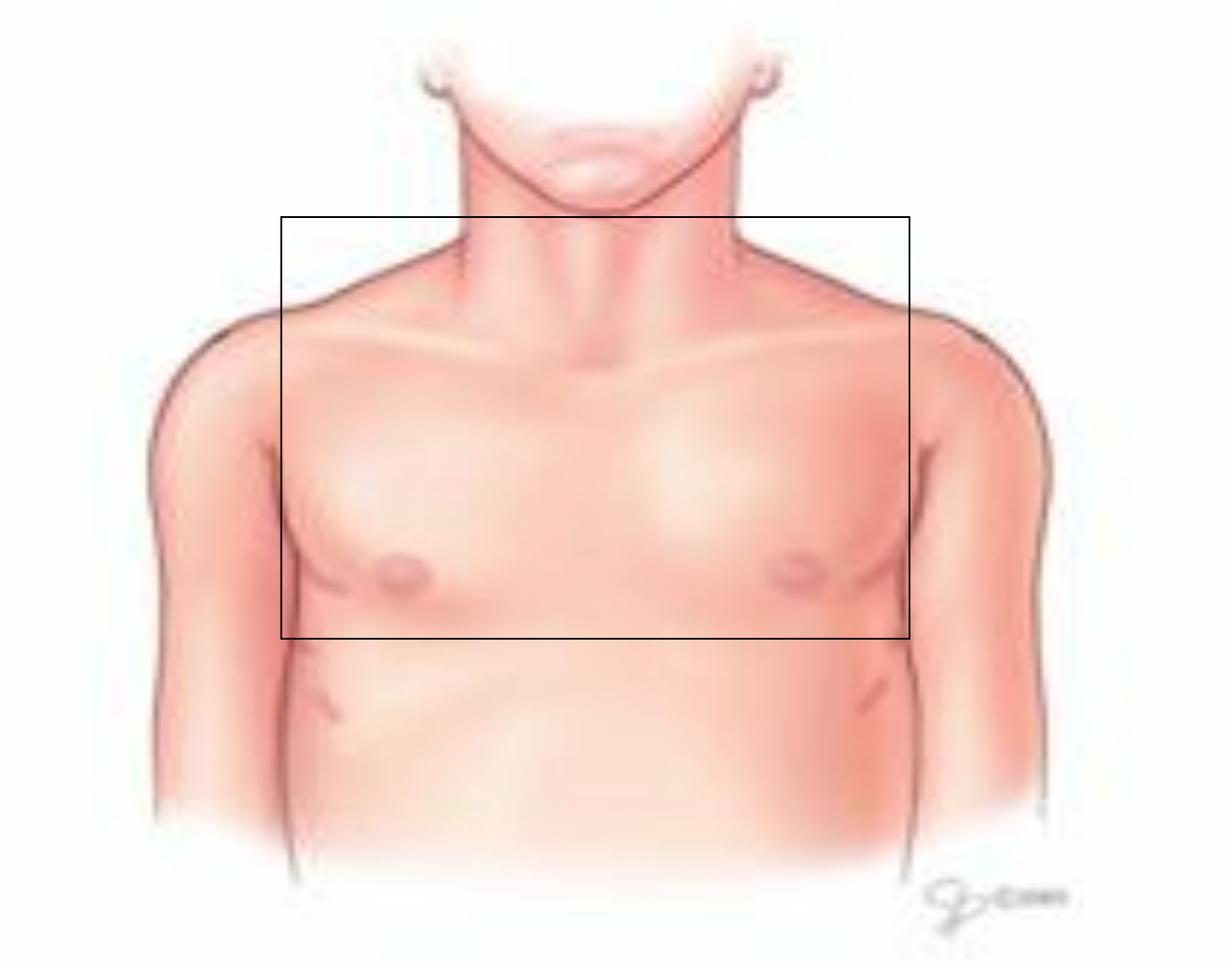
_____

_____

Nurse's Signature: _____

CULLMAN REGIONAL

Pacemaker Skin Prep Guideline for Hair Clipping



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