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-Vertebroplasty Admission Order Set
• Outpatient admission to :_____,MD. Notify MD of room assignment.
• Diagnosis:
• Allergies:
• Notify Cath Lab of Vertebroplasty per: _____MD.
• Vital signs routine.
• Activity: up ad lib
• 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).**
• Permit signed for Percutaneous ❑ Thoracic ❑ Lumbar Vertebroplasty with injection of cement into vertebral body.
• Start IV of D5 ½ NS @ KVO unless diabetic. If diabetic, NS @ KVO.
• Protime, PTT, platelets; place results on chart and notify MD if abnormal • Clip hair from appropriate procedure site prior to transport to Cardiovascular Services. Hair should be clipped with electric clippers.
• Ancef 1 gram IV on call immediately prior to procedure. If allergic to Penicillin; Cleocin 600 mg IV. *** Check with Radiologist if giving anything other than Ancef.**
• Take routine am medications except anticoagulants with sip of water.
MD Signature: _____ Date & Time:_____
▪ **Required** □ Optional

Cullman Regional Medical Center **Please use Ball Point Pen ONLY**

Revised: 09/26/17 **DO NOT USE: U IU QD QOD MS MSO4 MgSO4**

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Post Vertebroplasty Order Set

- Resume pre-procedure orders.
- Flat in bed x _____hours; HOB elevated 30-45 degrees for 1 hour; up to chair with assistance if desired after 1 hour elevation.
- Vital signs q 30 minutes x 2; q 1 hour x 2; then resume pre-procedure schedule.
- Observe for neurological changes; worsening back or lower extremity pain; lower extremity weakness and/or numbness; SOB with vital signs.
- Normal Saline @ _____ml/hr x _____hrs.
- Notify ❑ Primary MD ❑ _____ of acute changes or other problems.

MD Signature: _____Date & Time:_____

▪ **Required** □ Optional

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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: _____