UMC Health System

CARDIO PRE EP STUDY/ABLATION PLAN

Patient Label Here

PHYSICIAN ORDERS

Diagnosis _____

Weight _____ **Allergies** _____

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	Admit/Discharge/Transfer
	Request for Outpatient Services (Request Cardiac Outpatient Services) ☐ Location: Cath Lab
	Condition/Status
	If this patient is an OUTPATIENT, you MUST place the Code Status order below: **Code Status** ☐ Code Status: Full Code ☐ Code Status: DNR/AND (Allow Natural Death) ☐ Code Status: Care Limitation
	Cath Lab Procedure ☐ T;N, Electrophysiology Study (EPS) ☐ T;N, Other Procedure
	Patient Care
	Continuous Pulse Oximetry
	Continuous Telemetry (Intermediate Care)
	Obtain Consent ☐ Consent for: Electrophysiological Study/Ablation
	Weigh Patient One Time Order ☐ Record weight and height in the chart
	Insert Urinary Catheter ☐ To: Dependent Drainage Bag, Reason for Insertion: Selected surgical procedures, if patient unable to void prior to pre-medicating
	Patient Activity ☐ Up Ad Lib/Activity as Tolerated
	POC by Nursing
	POC ACT ☐ T;N
	POC Blood Sugar Check ☐ T;N
	POC Chem 8 ☐ T;N
	POC Hemoglobin and Hematocrit ☐ T;N
	POC PT with INR ☐ T;N
	TEE (Transesophageal Echo)
	Echo Transesophageal w/wo contrast (Card (TEE w/wo contrast (Cardio only)) ☐ Atrial Fibrillation
	Echo Transesophageal w/wo contrast (Card (TEE w/wo contrast (Cardio only)) ☐ Atrial Flutter

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Physician Signature: _____ **Date** _____ **Time** _____

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PHYSICIAN ORDERS	
Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.	
ORDER	**ORDER DETAILS**
	Obtain Consent ☐ Consent for: Transesophageal Echocardiogram
	TEE Medications
	lidocaine topical (Lidocaine Viscous 2% mucous membrane solution) ☐ 15 mL, swish &swallow, liq, as needed, PRN exam
	benzocaine topical (benzocaine 20% mucous membrane spray) ☐ 1 spray, mucous membrane, spray, as needed, PRN exam
	methylene blue ☐ 2 mg/kg, IVPush, inj, ONE TIME, PRN other IVPush over 5 minutes. For methemoglobinemia.
	Communication
	Notify Provider (Misc) ☐ Reason: if H&P is not on the chart
	Notify Provider (Misc) ☐ T;N, Reason: report last dose of anticoagulant, antiplatelet, and/or insulin.
	Notify Provider (Misc) ☐ Reason: of creatinine greater than 2.0 mg/dL
	Notify Provider (Misc) ☐ Reason: of INR greater than 1.5
	Pre-Op Patient ☐ Pre-Op for EP Study/Ablation, Clip hair, groin area.
	Pre-Op Patient ☐ Pre-Op for EP Study/Ablation, Clip hair chest/back area.
	Instruct Patient ☐ Instruct Patient On: Other Take the following medications the morning of procedure, with a sip of water, Please take:
	Notify Provider/Primary Team of Pt Admit ☐ Notify: Outpatient CV Fellow, Now
	Notify Provider/Primary Team of Pt Admit ☐ Now
	Dietary
	NPO Diet ☐ NPO After Midnight, Except Meds, NPO Reason: Procedure
	IV Solutions

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PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	NS ☐ IV, 50 mL/hr ☐ IV, 75 mL/hr ☐ IV, 100 mL/hr ☐ IV, 125 mL/hr ☐ IV, 150 mL/hr ☐ IV, 200 mL/hr
	D5 1/2 NS ☐ IV, 50 mL/hr ☐ IV, 75 mL/hr ☐ IV, 100 mL/hr ☐ IV, 125 mL/hr ☐ IV, 150 mL/hr ☐ IV, 200 mL/hr
	Laboratory
	IF NO RESULTS PAST 72 HOURS OR ABNORMAL RESULTS CALL PROVIDER **Click to review cardiac labs**
	Anti Xa Level ☐ STAT, T;N
	Basic Metabolic Panel (BMP) ☐ STAT, T;N
	Brain Natriuretic Peptide (proBNP) ☐ STAT, T;N
	CBC ☐ STAT, T;N
	Comprehensive Metabolic Panel ☐ STAT, T;N
	Digoxin Level ☐ STAT, T;N
	Hemoglobin A1C ☐ STAT, T;N
	Lipid Panel ☐ STAT, T;N
	Magnesium Level ☐ STAT, T;N
	Prothrombin Time with INR ☐ STAT, T;N
	PTT ☐ STAT, T;N
	T4 Free ☐ STAT, T;N
	TSH ☐ STAT, T;N
	Urinalysis ☐ Urine, STAT, T;N
	Urine Random Drug Screen ☐ Urine, STAT, T;N

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UMC Health System CARDIO PRE EP STUDY/ABLATION PLAN	Patient Label Here

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	ALL FEMALES OF CHILD BEARING YEARS UNLESS STERILE OR KNOWN PREGNANCY **POC Urine Pregnancy** ☐ T;N, STAT
	Beta HCG Serum Qualitative (Qualitative Beta HCG Serum) ☐ STAT, T;N
	Urine Beta hCG ☐ Urine, STAT, T;N
	Diagnostic Tests
	EKG-12 Lead ☐ T;N, STAT, Pre-Op exam
	Echo Transthoracic (TTE) with contrast i (Echo Transthoracic (TTE) with contrast if needed) ☐ STAT
	Limited Echo Transthoracic (Limited TTE) ☐ STAT
	Consults/Referrals
	Consult MD ☐ Service: Anesthesiology, Reason: Pre-Op EP Study/Ablation, Immediately
	...Additional Orders

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UMC Health System CONTRAST ALLERGY PREMEDICATION PROTOCOL	Patient Label Here

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	Patient Care
	Premedication Regimen to Reduce Contrast (Premedication Regimen to Reduce Contrast Reactions Protocol) ☐ T;N, ***See Reference Text***
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	Accelerated Premedication: Select methylprednisolone and ONE diphenhydramine. **methylPREDNISolone** ☐ 40 mg, IVPush, inj, q4h, x 24 hr, Solu-Medrol To be given every 4 hours until contrast study completed. Premedication for contrast allergy.
	Diphenhydramine to be given 1 hour before study with contrast, if possible. If study to be done in less than one hour, diphenhydramine will be given now. Select the following diphenhydramine if study is to be done in MORE than one hour. **diphenhydrAMINE** ☐ 50 mg, IVPush, inj, Pre Med, x 24 hr To be given 1 hour before study with contrast. Premedication for contrast allergy.
	Select the following diphenhydramine if study is to be done in LESS than one hour. **diphenhydrAMINE** ☐ 50 mg, IVPush, inj, ONE TIME Premedication for contrast allergy.
	Oral Elective Premedication: To be given 13 hours before study with contrast. **predniSONE** ☐ 50 mg, PO, tab, Pre Med, x 24 hr To be given 13 hours before study with contrast. Premedication for contrast allergy.
	To be given 7 hours before study with contrast. **predniSONE** ☐ 50 mg, PO, tab, Pre Med, x 24 hr To be given 7 hours before study with contrast. Premedication for contrast allergy.
	To be given 1 hour before study with contrast. **predniSONE** ☐ 50 mg, PO, tab, Pre Med, x 24 hr To be given 1 hour before study with contrast. Premedication for contrast allergy.
	diphenhydrAMINE ☐ 50 mg, PO, cap, Pre Med, x 24 hr To be given 1 hour before study with contrast. Premedication for contrast allergy.
	IV Elective Premedication: (if unable to take oral medications)

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Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

CONTRAST ALLERGY PREMEDICATION PROTOCOL

Patient Label Here

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	To be given 13 hours before study with contrast. **methylPREDNISolone** ☐ 40 mg, IVPush, inj, Pre Med, x 24 hr, Solu-Medrol To be given 13 hours before study with contrast. Premedication for contrast allergy.
	To be given 7 hours before study with contrast. **methylPREDNISolone** ☐ 40 mg, IVPush, inj, Pre Med, x 24 hr, Solu-Medrol To be given 7 hours before study with contrast. Premedication for contrast allergy.
	To be given 1 hour before study with contrast. **methylPREDNISolone** ☐ 40 mg, IVPush, inj, Pre Med, x 24 hr, Solu-Medrol To be given 1 hour before study with contrast. Premedication for contrast allergy.
	diphenhydrAMINE ☐ 50 mg, IVPush, inj, Pre Med, x 24 hr To be given 1 hour before study with contrast. Premedication for contrast allergy.

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UMC Health System

OUTPATIENT BB TYPE AND SCREEN

Patient Label Here

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	Laboratory
	BB Blood Type (ABO/Rh) ☐ Routine Outpatient/PACU, T;N, Vendor Bill No
	BB Antibody Screen ☐ Routine Outpatient/PACU, T;N, Vendor Bill No
	BB Clot to Hold ☐ Routine Outpatient/PACU, T;N, Vendor Bill No

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Physician Signature: _____ **Date** _____ **Time** _____