CATH LAB PRE PROCEDURE ORDERS- Page 1 of 2

NOTE: ❑ Only those orders checked (" ✓ ") will be executed. • All orders will be executed.

DRUG SENSITIVITY: *NKDA ❑

*Patient's Full Name: *Date of Birth:

*Date of Procedure: *Procedure time: • Obtain weight day of procedure *HT:_____WT: _____**KG**

*❑ Admit to Inpatient Status *❑ Place patient in Outpatient Status Code Status: ❑ Full Code ❑ DNR

***CONSENT TO READ** (Procedure to be Performed): ❑ Pt Verbally consented in office by MD prior to scheduled procedure

_____

_____

*Diagnosis_____ *ICD10 Code_____ *CPT Code_____

*TYPE OF ANESTHETIC SUGGESTED (may check more than one):

- Initiate Preoperative Anesthesia Protocol

❑ General ❑ Local ❑ Regional Block ❑ Moderate Sedation ❑ MAC Other_____

Anesthesiology Consult: Call Operating Room Scheduling for Anesthesiologist Consult at ext. 2050

* DIET ORDER:

❑ NPO after MN or _____ (Stress NO food, milk, OJ, clear liquids *per anesthesia protocol*)

Conscious sedation minimum NPO solid food is 6 hrs; minimum 2hr NPO for clear liquids

General anesthesia minimum NPO is 8 hrs. • Notify team if General anesthesia is ordered and patient is NPO <8 hrs.

Patient to take current medications prior to procedure? ❑ NO ❑ YES

❑ Patient to take HALF usual dose of Insulin morning of procedure ❑ Patient may continue current pain medications

*IV THERAPY: ❑ **Start IV** - if radial access planned, preferred IV location on opposite side of planned radial access site

- Interventional procedure: start two saline locks
- Diagnostic procedure: start one saline lock

❑ may use buffered Lidocaine 1%, 0.1ml intradermal for IV start

❑ NS 250ml IV bolus x1 then set at 75ml/ hr ❑ NS 500ml IV bolus x1 then set rate at 75ml /hr

❑ Other IV fluid orders: _____

*PRESCREENING EXAMINATION: • CBC & BMP Must be done within 30 days of patient receiving contrast

❑ CBC ❑ BMP ❑ PT/PTT ❑ Lipid panel ❑ Liver function panel ❑ P2Y12

❑ T&S ❑ T&C # Units:_____

• All diabetic patients obtain glucose pre procedure

• HCG qual for all females <55, if not required please note reason_____

❑ CXR ❑ EKG

Other_____

*COVID-19 SCREEN:

❑ Nasopharyngeal swab, for Anesthesia/ aerosolized procedures only / * rapid test considered for emergency/ approved cases only

MRSA SCREEN:

❑ Complete if patient high-risk (I.e. Any transfer from another facility/ patients receiving the following surgical procedures: CABG and/or Valve Replacement/Total Joint Replacement/Lumbar Laminectomies/Spinal Fusions/Anterior and Posterior Cervical Fusions)

ALASKA REGIONAL HOSPITAL

_____ **ORDERS**

POS

PLACE PATIENT LABEL HERE

Form:

PRE PROCEDURE PREP: ❑ **Clip and wash** SITE with Chlorhexidine Surgical Scrub (*Betadine if allergic*)
❑ **Clip and wash** SITE with ChloraPrep Scrub (betadine if allergic

- Must clip from chin to nipple line for all Pacemakers
- **EP** study/ ablations must be clipped anterior & posterior from chin to waist

❑ Prep Bilateral groin access; plan for ❑ Right / ❑ Left Femoral access
❑ Clip bilateral groin and prep for **RIGHT** Radial access ❑ Clip bilateral groin and prep for **LEFT** Radial access
❑ Prep **Radial** site with EMLA cream 45 min prior to procedure; Apply from wrist to elbow fold & cover with Tegaderm

❑ Foley catheter to be placed in CL Lab ❑ NG tube placement in CL Lab

*PROCEDURE MEDICATIONS:

❑ Valium 5mg PO x 1 dose OR ❑ Valium 10mg PO x 1 dose
❑ Benadryl 25mg PO x 1 dose OR ❑ Benadryl 50mg PO x 1 dose
❑ ASA 325mg PO x 1 OR ❑ ASA 81mg PO x 1 if not taken this am
❑ Plavix 600mg PO x 1 OR ❑ Plavix 300mg PO x 1 OR ❑ Brilinta 180mg PO x 1
❑ Acetyeysteine 600mg PO x 1 – If creatinine ≥ 1.5 mg/dL OR diabetic patient
❑ Other: _____
_____

*CONTRAST ALLERGY MEDICATION ORDERS:

PLEASE INDICATE MEDICATION ORDERS AND DOSING PLAN

ANTIBIOTIC:** ***Prophylactic Antibiotic to be Received within One Hour Prior to Surgical Incision*

❑ **NA**
❑ Cefazolin 2 g *(Patients <120 kg)* OR Cefazolin 3 g *(Patients ≥120 kg)* IV x 1 dose
❑ Vancomycin 15 mg/kg rounded to nearest 250 mg IV x 1 dose
❑ Clindamycin 900 mg IV x1 dose
❑ **Other Antibiotic:** _____

All outside test results to be delivered to Admitting or faxed to (907) 264-2076 & (866) 605-9602

❑ H&P completed within 30 days ❑ H&P to be updated day of procedure

***ADDITIONAL ORDERS:**

* _____ _____ _____
PHYSICIAN SIGNATURE ***DATE*** ***TIME***

Telephone Order. Received From: _____**(*LIP)**	**Date**_____	**Time**_____ _
Telephone Order Written, Read Back & Verified by RN:_____	**Date**_____	**Time**_____ _

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_____ ORDERS

POS

POS Form:

PLACE PATIENT LABEL HERE