



PHYSICIAN'S ORDER SHEET

- 1. ENSURE PHARMACY COPY IS PRESENT BEFORE WRITING MEDICATION ORDERS
2. START EACH DAY'S MEDICATION ORDERS AND GENERAL ORDERS AT THE SAME HORIZONTAL LEVEL.
3. DO NOT ADD OR CHANGE ORDERS IN ANY SECTION WHERE ORDERS HAVE PREVIOUSLY BEEN WRITTEN.

Use Ball Point - Press Firmly

PRE-CORONARY ANGIOGRAM/ANGIOPLASTY/STENT PROCEDURE

Form header with fields for Drug Allergies, Medication Orders, General Orders, and Patient Information (Height, Weight, Date, Time).

These orders are to be used as a guideline and do not replace sound clinical judgement and professional practice standards. Patient allergy and contraindications must be considered when completing these orders.

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Date and Time selection fields

Procedure Scheduled for: DATE AND TIME

Intravenous Hydration: Please review Inclusion and Exclusion Criteria for suggested hydration.

Inclusion Criteria for Hydration:

- 1. eGFR less than 60 mL/min. (follow order #1)
2. eGFR greater than 60 mL/min. (follow order #2)

Exclusion Criteria for Hydration:

- 1. CHF with NYHA Class 3-4 symptoms.
2. Suspected severe aortic stenosis
3. Respiratory distress (respiratory rate greater than 18 breaths/minute and/or oxygen saturation less than 94% on room air)
4. Peritoneal Dialysis or Hemodialysis

Calculate eGFR

Patient formula for calculation of estimated Glomerular Filtration Rate (eGFR) on reverse of page.

- 1. If eGFR is less than 60 mL/min: give IV normal saline 3 mL/kg IV over 1 hour pre procedure then continue at 1 mL/kg/hr for 6 hours post procedure.
2. If eGFR is greater than 60 mL/min. Establish IV normal saline at mL/hr. (usual rate 100 mL/hr) Start IV 1 to 2 hours pre-procedure.

Medications:

- Give usual medications with a small amount of water unless otherwise ordered. May use patient's own meds. NOTE: If patient is stable hold diuretics in a.m. pre-procedure.
If patient is using sublingual nitroglycerin, send sublingual nitroglycerin with patient to Cath Lab.
Ensure ASA mg (usual dose 80 mg, 81 mg or 325 mg) orally x 1 given pre-procedure if no allergy. If allergy or contraindication to acetylsalicylic acid is present, contact the Interventional Cardiologist for direction.

PHYSICIAN'S SIGNATURE

PRINTED NAME

GENERIC EQUIVALENT AUTHORIZED

- ACP Status: Comfort Care, Medical Care, Resuscitation
Record height and recent weight on chart.
Current history and physical documented on chart.
Send previous CABG, PTCA/Stent and angiogram report(s) to Cath Lab.
NOTE: Procedure may be cancelled if reports not available.
Copy of Diagnostic Tests (e.g. Stress Test, MIBI, Echo, MRI, CT, Angiogram) to Cath Lab.
If a previous severe reaction to x-ray dye, (e.g. airway compromise, hypotension, or severe hives) See allergy protocol on reverse for suggested management.
NPO after midnight, except for medication to be taken with a small amount of water
Activity as tolerated.
Baseline vital signs.
ECG: Inpatients: within 1 week pre-procedure, or after any change in cardiac status. Outpatients: within 4 weeks
CBC, INR, Na, K, Cl, glucose, urea, creatinine, estimated Glomerular Filtration Rate
Inpatients: within 48 to 72 hours
Outpatients: within 12 weeks
NOTE: If abnormal lab results, recheck within 24 hrs pre-procedure.
If on warfarin, perform bloodwork on the day prior to the procedure. Ensure INR less than or equal to 1.7.
If patient currently taking diuretics and potassium level is greater than 5.2 or less than 3.5, recheck potassium level within 24 hrs pre-procedure. Contact referring physician
If diabetic, check glucose by glucometer in the a.m. pre-procedure. If blood sugar is less than 5 or greater than 18 mmol/L, notify referring physician
Ensure patient voids prior to transfer to Cath Lab.

## **GFR Calculator**

### **Using the MDRD eGFR Calculator at [www.mdrd.com](http://www.mdrd.com)**

1. Change Serum Creatinine to umol/L for units of measurement and enter Serum Creatinine Value
2. Change Age: To the age of patient
3. Select appropriate race and gender
4. Leave IDMS at Yes
5. Use MDRD GFR Value
6. Select the appropriate IV Hydration order according to eGFR value

### **If patient has *renal insufficiency*, suggest:**

1. Adjust IV rate according to eGFR value of less than 60 mL/min. (order # 1)
2. Encourage oral fluids day prior to procedure
3. Suggest repeat serum creatinine 48 hours post procedure. If elevated from baseline, repeat serum creatinine in one week

### **SUGGESTED ALLERGY PROTOCOL:**

Prednisone 50 mg orally	}	to be given at 1800h with food evening before and in a.m. pre-procedure
Ranitidine 150 mg orally		
Diphenhydramine 25 mg orally		

**Legend:** ASA - Acetylsalicylic acid  
CABG - Coronary Artery Bypass Graph  
CBC - Complete blood count  
Cl - Chloride  
ECHO - Echocardiogram  
INR - International Normalized Ratio  
K - Potassium  
MIBI - Myocardial Perfusion Scan  
MRI - Magnetic Resonance Imaging  
Na - Sodium  
PTCA - Angiogram and Percutaneous Transluminal Coronary Angioplasty



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**PRE-CORONARY ANGIOGRAM/ANGIOPLASTY/STENT PROCEDURE**

Drug Allergies	ORDER TRANSCRIBED AND ACTIVATED	DATE _____	TIME _____
_____		Patient's Height _____	Patient's Weight _____

<b>R<sub>x</sub></b> MEDICATION ORDERS TO BE INITIATED OR DISCONTINUED		TEST DONE	GENERAL ORDERS
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<ul style="list-style-type: none"> <li>■ If patient is already on a statin (atorvastatin, rosuvastatin, simvastatin, pravastatin, lovastatin, fluvastatin) continue previous drug at home dose. If patient currently does not take a statin: ensure no allergy or previous myositis/hepatitis to statin medications, proceed with:             <ul style="list-style-type: none"> <li><input type="checkbox"/> Atorvastatin 80 mg orally x 1, give 24 hours prior to angiogram procedure.</li> </ul> </li> <li>■ If Diabetic:             <ul style="list-style-type: none"> <li><input type="checkbox"/> Hold oral antidiabetic medications in a.m. pre-procedure</li> <li><input type="checkbox"/> Hold metformin in a.m. of procedure and for 48 hrs</li> <li><input type="checkbox"/> If on insulin: <b>At bed time prior to procedure, administer the following insulin:</b> Insulin _____ Insulin _____ (Suggested schedule: ½ the usual dose of long acting insulin and full dose of short acting insulin <b>In a.m. pre-procedure: After the IV is established and the glucometer check is done, administer</b> Insulin _____ (Suggested schedule: give ½ the usual <b>total</b> morning Insulin dose <b>using long acting Insulin only</b></li> </ul> </li> </ul> <p><b>NOTE:</b> If procedure delayed past 1000h check blood sugar q2hr. <b>Notify Attending Physician (Referring)</b> if blood sugar less than 5 or greater than 18 mmol/L</p>	<ul style="list-style-type: none"> <li>■ Please do not remove hearing aids, dentures and glasses from patient.</li> <li><input type="checkbox"/> CK level in Cath Lab pre-procedure</li> <li><input type="checkbox"/> Give requisition to patient to repeat plasma creatinine in 2 days if eGFR &lt; 30 mL/minute/ 1.73 m<sup>2</sup> or in 7 days if eGFR 30-60 mL/minute/1.73m<sup>2</sup>. Clearly identify referring physician and fax number on requisition.</li> </ul>
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PRINTED NAME _____
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Drug Allergies, ORDER TRANSCRIBED AND ACTIVATED, DATE, TIME, Patient's Height, Patient's Weight

Rx MEDICATION ORDERS TO BE INITIATED OR DISCONTINUED, TEST DONE, GENERAL ORDERS

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Main body of the order sheet containing various checkboxes and notes regarding medication management, heparin use, and PTCA/Stents.

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