Hôpital St-Boniface Hospital

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

POST-CORONARY ANGIOPLASTY/STENT/GP IIb IIIa INHIBITOR INFUSION

Drug Allergies ➲ ➨ ➨	ORDER TRANSCRIBED AND ACTIVATED		DATE TIME Patient's Height Patient's Weight
℞ MEDICATION ORDERS TO BE INITIATED OR DISCONTINUED		TEST DONE	GENERAL ORDERS

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■ ***Automatically Activated*** ☐ ***Activated by Checking Box***

Date: D D M M M Y Y Y Y Time: 24 HOUR

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 1hour 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/h) x 3 hours post procedure.

Medications:

■ Confirm resumption of pre procedure medications with Medication Reconciliation Sheet/Medication Administration Record.

Overnight patients may use own medications.

■ If patient not receiving clopidogrel or ticagrelor, ensure loading dose is given
- ☐ Clopidogrel 300 mg orally
- ☐ Clopidogrel 600 mg orally
- ☐ Ticagrelor load 180 mg orally once prior to procedure. (restricted to Interventional Cardiology)

PHYSICIAN'S SIGNATURE ______________________________

PRINTED NAME ______________________________

GENERIC EQUIVALENT AUTHORIZED

☐ **Post Radial Puncture:**

■ Complete bedrest while trans radial compression band in place. Head of bed may be elevated for patient comfort.

■ Activity as tolerated after removal of trans radial compression band and if puncture site stable. Avoid flexing of affected wrist.

☐ **Post Femoral Puncture without closure device:**

Complete bedrest x __________ hours post hemostasis with affected limb straight. May be up at __________ h, if no hematoma or bleeding.

☐ **Post Femoral Puncture with closure device**:

Complete bedrest for one hour with affected limb straight or____ hours.

■ Activity as tolerated post-bedrest if puncture site stable. Avoid excessive flexing of affected limb. Avoid straining with bowel movement.

■ Bleeding Management: Apply direct pressure for 10 minutes until hemostasis achieved. If bleeding continues, maintain direct pressure and notify Interventional Cardiologist.

■ If hematoma occurs document size and notify Interventional Cardiologist.

NOTE: Bedrest x 3 hours post femoral bleed.

■ Upon arrival to patient care unit, assess puncture site, vital signs, and colour, warmth, circulation, movement (cwcm) of affected limb.
- q 15 min x 2
- q 30 min x 2
- q 1hr x 2 then with;
- routine vital signs as ordered and prn.

■ Oxygen @ 3L/NP to maintain oxygen saturation above 92%.

■ If diabetic, check blood sugar by glucometer on return to patient care unit.

■ Resume previous diet orders as tolerated. **Encourage** fluids unless contraindicated.

■ ☐ Inpatient: if baseline creatinine elevated, repeat serum creatinine 48 - 96 hours post-procedure.
☐ Outpatient: mandatory blood requisition for serum creatinine 5 days post-procedure

■ Straight catheterization prn x 1. If still unable to void insert foley catheter. Discontinue catheter by 0600h or when ambulating.

AUTHORIZED BY PROGRAM MANAGEMENT TEAM: **CARDIAC SCIENCES PROGRAM**
May 19, 2015 7102-3151-7

GFR Calculator

Using the MDRD eGFR Calculator at 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
Ranitidine 150 mg orally
Diphenhydramine 25 mg orally
} to be given at 1800h with food evening before and in a.m. pre-procedure

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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POST-CORONARY ANGIOPLASTY/STENT/GP IIb IIIa INHIBITOR INFUSION

Drug Allergies ➲ ➨ ➨	ORDER TRANSCRIBED AND ACTIVATED	DATE TIME Patient's Height ________ Patient's Weight ________
℞ MEDICATION ORDERS TO BE INITIATED OR DISCONTINUED	⬇ | TEST DONE	GENERAL ORDERS

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MEDICATION ORDERS

Maintenance Dose

- ■ ☐ Clopidogrel ______mg orally (usual dose 75 mg) once daily
  - ☐ Ticagrelor 90 mg orally twice daily
- ■ Enteric coated acetylsalicylic acid ________ mg (usual dose 81 mg or 325 mg) orally once a day, if not allergic to acetylsalicylic acid. * Elder Alert - if on Ticagrelor, maximum dose of acetylsalicylic acid is 100 mg.
- ☐ If diabetic
  - ☐ Restart the oral antidiabetic agent post-procedure if blood sugar within acceptable range (5 - 18 mmol/L)

    NOTE: hold metformin x 48 hours.
  - ☐ If baseline serum creatinine normal pre-procedure, restart metformin at 48 hours.

    If serum creatinine levels are elevated, the use of metformin should be reassessed.
  - ☐ Give usual dose of pre-meal insulin post-procedure if patient eating and drinking and blood sugar within acceptable range (5 - 18 mmol/L)
- ■ If on warfarin or alternative (apixaban, dabigatran or rivaroxaban) pre-procedure, restart usual dose/schedule 4 hours after ambulation if no bleeding or hematoma, unless instructed otherwise.
- ☐ Discontinue low molecular weight heparin (enoxaparin/ dalteparin) and fondaparinux.
- ☐ Discontinue unfractionated heparin IV
- ☐ Acetaminophen 325 - 650 mg orally q4h prn for pain x 24 hours. (maximum 4 grams acetaminophen daily)
- ☐ Acetaminophen with codeine 30 mg 1 - 2 tabs orally q4h for pain x 24 hours. (maximum 4 grams acetaminophen daily)
- ☐ Lorazepam 0.5 - 1 mg orally q6h prn for anxiety x 24 hours.
- ☐ Metoclopramide 5 - 10 mg IV q6h prn for nausea x 24 hours.
- ☐ Dimenhydrinate 25 - 50 mg IV q4h prn for nausea x 24 hours.
- ☐ Ondansetron 8 mg IV or po q8h prn for nausea

PHYSICIAN'S SIGNATURE ____________________

PRINTED NAME ____________________
GENERIC EQUIVALENT AUTHORIZED

GENERAL ORDERS

- ■ 12 lead ECG upon arrival to patient care unit. Stat ECG with angina or signs/symptoms suggestive of angina. Review ECG with M.D.
- ■ Discontinue IV Infusion when GP IIb/IIIa inhibitor infusion (eptifibatide [Integrilin®] or abciximab [Reopro®]) completed, when vital signs and puncture sites stable, patient voided, diet and activity are tolerated.
- ■ Avoid unnecessary venous and arterial punctures, IM injections and non-compressible IV sites if receiving GP IIb/ IIIa inhibitor infusion (eptifibatide [Integrilin®] or abciximab [Reopro®]).
- ☐ Telemetry is required. Monitor until _____ h or for ___ hours.

Lab Work:

- ☐ CK at 12 hours post-procedure. **Notify** Interventional Cardiologist if CK greater than 200 units/L.

  NOTE: If between 2200 - 0700 h and patient is clinically stable, notify Interventional Cardiologist in a.m. of elevated CK
  - ☐ Inpatient. If baseline creatinine elevated, repeat serum creatinine 48 - 96 hours, post-procedure. Attending provider to be notified of results.
  - ☐ Outpatient. Mandatory blood requisition 5 days post procedure.
- ■ For patients on GP IIb/IIIa inhibitor infusion (eptifibatide/ [Integrilin®] or abciximab [Reopro®]):

  CBC stat, ☐ 2 hours and ☐ 12 hours post GP IIb/IIIa inhibitor initial bolus.

  NOTE: "**GP IIb IIIa inhibitor infusion**" must be written on CBC requisition.
- ■ **If platelets less than 100 x 10^9/L notify Interventional Cardiologist immediately** (May require stopping of the GP IIb/IIIa inhibitor infusion (eptifibatide [Integrilin®] or abciximab [Reopro®]) or may require platelet transfusion)

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POST-CORONARY ANGIOPLASTY/STENT/GP IIb IIIa INHIBITOR INFUSION

Drug Allergies ➲

➨ ➨

ORDER TRANSCRIBED AND ACTIVATED

DATE TIME

Patient's Height ----------

Patient's Weight ----------

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GP IIb IIIa Inhibitor Patient weight ____________ Kg

DO NOT USE eptifibatide (Integrilin®) if eGFR is less than 30 mL/min. Eptifibatide (Integrilin®):

For patients with eGFR greater than 50 mL/min.

☐ Eptifibatide (Integrilin®) IV bolus 180 mcg/kg =________ mg of 2 mg/mL concentration given at ________ h. (maximum total IV bolus dose 22.6 mg)

☐ Eptifibatide (Integrilin®) IV infusion 2 mcg/kg/min to be infuse at ______ mL/h of 0.75 mg/mL concentration x ______ hours up to a maximum of 20 mL/hour.

Infusion started at ______ h Date D D M M M Y Y Y Y

D/C infusion at ______ h Date D D M M M Y Y Y Y

☐ Give second IV bolus eptifibatide (Integrilin®) 180 mcg/kg= ________ mg of 2 mg/mL concentration 10 minutes after initial bolus is started. Given at ______ h hours (maximum total IV bolus dosage of 22.6 mg)

For patients with eGFR between 30-50 mL/min:

☐ Eptifibatide (Integrilin®) IV infusion 1 mcg/kg/min. Infuse at ______ mL/hour of 0.75 mg/mL concentration x ________ hrs up to a maximum of 10 mL/hr.

Infusion started at ______ h Date D D M M M Y Y Y Y

D/C infusion at ______h Date D D M M M Y Y Y Y

Abciximab® (ReoPro®):

■ Abciximab (ReoPro®) infusion to run alone through dedicated IV line.

■ Maintain 2 IV sites for the duration of the abciximab (ReoPro®) infusion.

☐ Abciximab (Reopro®) IV bolus 0.25 mg/kg =________ mg of 2 mg/mL concentration given at ______ h.

☐ Abciximab (Reopro®) IV infusion at 0.125 mcg/kg/min (9 mg added to 250 mL NS [concentration 0.0353 mg/mL] to be infused at ______mL/h (to a maximum 17 mL/h x 12 hours.

IInfusion started at ______ h Date D D M M M Y Y Y Y

D/C infusion at ______h Date D D M M M Y Y Y Y

PHYSICIAN'S SIGNATURE ________________________

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GENERIC EQUIVALENT AUTHORIZED

Discharge Planning:

■ If stent inserted, issue stent card and stent letter/ pamphlet.

■ Elective patients may be discharged in a.m. if vital signs stable, labs reviewed, no hematoma, patient ambulating and voiding post-procedure.

■ Ensure discharge patient information sheet reviewed with patient prior to discharge.

■ Ensure patient has prescription for ASA or other anti-platelet agents eg. clopidogrel, ticagrelor.

■ **Notify Interventional Cardiologist** if considering discontinuation of **GP IIb/IIIa** (eptifibatide [Integrilin®] or abciximab [Reopro®]), **ASA**, **clopidogrel** or ticagrelor due to bleeding.

☐ Same Day Discharge Patients

- ☐ Prior to discharge blood work to be drawn
- ☐ CK at 6 hours post procedure
- ☐ Ensure patient has prescriptions for ASA/clopidogrel or alternate agents
- ☐ Notify Interventional Cardiologist about access site and cardiac issues to ensure patient stablity prior to same day discharge.

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7102-3151-7