

PHYSICIAN'S ORDER SHEET
POST CORONARY ANGIOPLASTY/STENT/GPIIb IIIa
INHIBITOR INFUSION
Part 1 of 3

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.

Automatically Activated

Activated by Checking Box

ALL MEDICATION and INTRAVENOUS ORDERS				GENERAL ORDERS			
ORDER #	DATE	TIME		ORDER #	DATE	TIME	
<p>Intravenous: May need to be adjusted for class 3-4 CHF.</p> <ul style="list-style-type: none"> ■ 1. Establish IV normal saline @ 100 ml/h x 3 h, then TKO when tolerating fluids. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> ■ 2. If serum creatinine is ≥ 140 umol/L or Creatinine Clearance < 60 ml/min continue Sodium Bicarbonate IV @ 1 ml/kg/hr (____ ml/hr) x ____ hours. <p>Medications:</p> <ul style="list-style-type: none"> ■ 3. Resume pre-procedure medications. Overnight patients may use own medications. ■ 4. If serum creatinine ≥ 140 umol/L or Creatinine Clearance < 60 ml/min give N-acetylcysteine 600 mg po bid procedure day. ■ 5. If patient not receiving Clopidogrel 75 mg od ensure load dose of Clopidogrel given <ul style="list-style-type: none"> <input type="checkbox"/> Clopidogrel 300 mg if procedure > 12 hrs away <input type="checkbox"/> Clopidogrel 600 mg if procedure < 12 hrs away ■ 6. Clopidogrel 75 mg po od x ____ weeks ■ 7. EC ASA ____ mg po od if not allergic to ASA. <input type="checkbox"/> 8. If diabetic: <ul style="list-style-type: none"> <input type="checkbox"/> restart the oral antidiabetic agent post-procedure if blood sugar within acceptable range (5-18 mmol/L) <p>NOTE: Hold Metformin x 48 hours.</p> 9. <input type="checkbox"/> If baseline creatinine normal pre-procedure, restart Metformin @ 48 hours. <p>If creatinine levels are elevated, the use of Metformin should be reassessed.</p> 10. <input type="checkbox"/> Give usual dose of pre-meal insulin post-procedure if patient eating and drinking and blood sugar within acceptable range (5-18 mmol/L) ■ 11. If on Warfarin pre-procedure, restart usual dose/schedule 4 h after ambulation if no bleeding or hematoma unless instructed otherwise. 				<ul style="list-style-type: none"> ■ 1. Complete bedrest x ____ hours post-hemostasis with affected leg straight. May be up @ ____ hours, if no hematoma or bleeding. - If Radial approach used, please see Physician specific orders. ■ 2. Bleeding Management: apply direct pressure for 10 minutes until hemostasis achieved. If bleeding continues maintain direct pressure and notify Interventional Cardiologist. NOTE: Bedrest x 3 hours post bleed. ■ 4. If hematoma occurs, document size and notify Interventional Cardiologist. ■ 5. Activity as tolerated after assigned bedrest, if puncture site stable. ■ 6. Abciximab (ReoPro) infusion to run alone through dedicated IV line. ■ 7. Maintain 2 IV sites for the duration of the Abciximab (ReoPro) infusion. ■ 8. Upon arrival to patient care unit, assess puncture site, vital signs and CWCM of affected limb: <ul style="list-style-type: none"> q 15 min x 2 q 30 min x 2 q 1 hour x 3 q 4 hour x 4 then routine vital signs as ordered and PRN. <p>Lab Work:</p> <ul style="list-style-type: none"> ■ 9. CK - @ 12 hours post-procedure. Notify Interventional Cardiologist if CK > 200 <p>NOTE: If between 2200-0700 hrs and patient is clinically stable, notify Interventional Cardiologist in am of elevated CK</p> <ul style="list-style-type: none"> ■ 10. If baseline creatinine elevated, repeat serum creatinine 48-96 hrs, post-procedure. Attending provider to be notified of results. ■ 11. For patients on GP IIb IIIa inhibitor infusion: CBC stat @ ■ 2h & ■ 12h post GP IIb IIIa inhibitor initial bolus <p>NOTE: "GP IIb IIIa inhibitor infusion" must be written on CBC requisition.</p>			
<p>PHYSICIAN'S SIGNATURE (GENERIC EQUIVALENT AUTHORIZED) _____ M.D.</p>							
<p>FAX SENT <input type="checkbox"/> DATE _____ TIME _____</p>							

If patient has renal insufficiency, suggest:

Serum Creatinine \geq 140 μ mol/L or Creatinine Clearance < 60 ml

1. Encourage oral fluids day prior to procedure.
2. N-acetylcysteine 600 mg po bid day prior and procedure day.
3. Pre-hydration sodium bicarbonate solution:
Mixture for sodium bicarbonate solution:
- Add three (3) 50 ml amps (150 ml) 8.4% Sodium Bicarbonate (1 mEq/ml) to a 1000ml bag 5% D/W.
4. Suggest repeat serum creatinine 48 hours post procedure. If elevated from baseline, repeat serum creatinine in one week.

Suggested allergy protocol:

Prednisone 50 mg PO

Ranitidine 150 mg PO

Diphenhydramine 25 mg PO



to be given @ 1800 hours with food evening before and in AM pre-procedure



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<input checked="" type="checkbox"/>			12. Acetaminophen 325 mg 1-2 tabs po q 4h prn for pain x 24 hours. OR	<input checked="" type="checkbox"/>			12. If platelets < 100 x 10 ⁹ /L notify Interventional Cardiologist immediately (may require stopping of the GP IIb IIIa inhibitor infusion or may require platelet infusion)
<input checked="" type="checkbox"/>			13. Acetaminophen with codeine 30 mg 1-2 tabs po q4h for pain x 24 hours.	<input checked="" type="checkbox"/>			13. If diabetic, preform blood sugar check on return to patient care unit.
<input checked="" type="checkbox"/>			14. Lorazepam 0.5 - 1 mg po q6h prn x 24 hours.	<input checked="" type="checkbox"/>			14. 12 lead EKG upon arrival to patient care unit. Stat EKG with angina or signs suggestive of angina. Review EKG with a M.D.
<input checked="" type="checkbox"/>			15. Metoclopramide 5-10 mg IV q6h prn for nausea x 24 hours. OR	<input checked="" type="checkbox"/>			15. Discontinue IV when GP IIb IIIa inhibitor infusion completed; when vital signs and puncture sites stable, patient voided, diet and activity are tolerated, unless otherwise indicated.
<input type="checkbox"/>			16. Dimenhydrinate 25-50 mg IV q4h prn for nausea x 24 hours.	<input checked="" type="checkbox"/>			16. Avoid unnecessary venous and arterial punctures, IM injections and non - compressible IV sites if receiving GP IIb IIIa inhibitor infusion.
			If Receiving Eptifibatide (Integrilin): Do not use if serum creatinine > 350 mmol/L	<input type="checkbox"/>			17. Telemetry is required. Monitor until _____ hours.
<input type="checkbox"/>			17. Eptifibatide (Integrilin) IV bolus 180 mcg/kg _____ mg of 2mg/ml concentration given at _____ hours. (maximum single IV bolus dose 22.6 mg)	<input checked="" type="checkbox"/>			18. Resume previous diet orders as tolerated (cold finger food diet). Encourage fluids unless contraindicated.
<input type="checkbox"/>			18. Eptifibatide (Integrilin) IV infusion 2 mcg/kg/min infuse at _____ mls/hour of 0.75 mg/ml concentration x _____ hours. (Usual 18-24 hours) up to a maximum of 20 mls/hour or 125 kg. Infusion started at _____ hours D/C infusion at _____ hours Date: dd ____ mm ____ yyyy ____	<input checked="" type="checkbox"/>			19. Straight catheterization prn x 1. If still unable to void insert Foley catheter. Discontinue catheter by 0600h or when ambulating.
<input type="checkbox"/>			19. Give second IV bolus Eptifibatide (Integrilin) 180 mcg/kg _____ mg of 2 mg/ml concentration 10 minutes after initial bolus is started. Given at _____ hours (up to a maximum single IV bolus dosage of 22.6 mg)				

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ALL MEDICATION and INTRAVENOUS ORDERS

GENERAL ORDERS

ORDER #	DATE	TIME	ORDER #	DATE	TIME
<input type="checkbox"/> 20.			<input checked="" type="checkbox"/> 20.		
<p>NOTE: For serum creatinine between 175-350 umol/L:</p> <p>Eptifibatide (Integrilin) IV infusion 1 mcg/kg/min. Infuse at _____ mls/hour of 0.75 mg/ml concentration x _____ hours (usual 18-24 hours) up to a maximum of 10 mls/hour or 124 kg. Infusion started at _____ hours. D/C infusion at _____ hours. Date: dd _____ mm _____ yyyy _____</p> <p>If receiving Abciximab (Reopro):</p>			<p><input checked="" type="checkbox"/> 20. If stent inserted, issue stent card and stent letter/pamphlet.</p> <p><input checked="" type="checkbox"/> 21. Elective patients may be discharged in AM if vital signs stable, labs reviewed, no hematoma, patient ambulating and voiding post-procedure.</p> <p><input checked="" type="checkbox"/> 22. Ensure discharge patient information sheet reviewed with patient prior to discharge.</p> <p><input checked="" type="checkbox"/> 23. Ensure patient has prescription for ASA and Clopidogrel.</p> <p><input type="checkbox"/> 24. If considering discontinuation of: GP IIB/IIIa ASA Clopidogrel due to bleeding, notify Interventional Cardiologist.</p>		
<input type="checkbox"/> 21.					
<p>Abciximab (Reopro) IV bolus 0.25 mg/kg _____ mg of 2 mg/ml concentration given at _____ hours.</p>					
<input type="checkbox"/> 22.					
<p>Abciximab (Reopro) IV infusion @ 0.125mcg/kg/min (9 mg. in 250 mls NS concentration 0.036mg/ml) infusion at _____ mls/hour (to a maximum 17 mls/hour or max body weight 80kg) x 12 hours. Infusion started at _____ hours D/C infusion at _____ hours Date: dd _____ mm _____ yyyy _____</p>					
<input type="checkbox"/> 23.					
Discontinue LMWH/Fondaparinux					
<input type="checkbox"/> 24.					
Discontinue UFH IV					
<p>PHYSICIAN'S SIGNATURE (GENERIC EQUIVALENT AUTHORIZED)</p>			<p>M.D.</p>		
FAX SENT	DATE	TIME			
<input type="checkbox"/>					