

General

Elective Outpatient, Observation (Single Response)

<input type="checkbox"/> Elective outpatient procedure: Discharge following routine recovery	Routine, Continuous, PACU & Post-op
<input type="checkbox"/> Outpatient observation services under general supervision	Admitting Physician: Patient Condition: Bed request comments: PACU & Post-op
<input type="checkbox"/> Outpatient in a bed - extended recovery	Admitting Physician: Bed request comments: PACU & Post-op

Elective Outpatient, Observation (Single Response)

Patient has active outpatient status order on file

<input type="checkbox"/> Outpatient observation services under general supervision	Admitting Physician: Patient Condition: Bed request comments: PACU & Post-op
<input type="checkbox"/> Outpatient in a bed - extended recovery	Admitting Physician: Bed request comments: PACU & Post-op
<input type="checkbox"/> Transfer patient	Level of Care: Bed request comments: Scheduling/ADT
<input type="checkbox"/> Return to previous bed	Routine, Until discontinued, Starting S, Scheduling/ADT

Return to Floor

Return to Floor (Single Response)

<input type="checkbox"/> OK to return to previous IP bed	Routine, Until discontinued, Starting S, PACU
<input type="checkbox"/> OK to return to IP bed after 1hr in PACU	Routine, Until discontinued, Starting S, PACU

Nursing

Radial - Sheath Removal

<input type="checkbox"/> Radial Compression Device (Selection Required)	
<input type="checkbox"/> NOTIFY: The physician must be notified prior to sheath removal of a systolic blood if pressure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal if systolic blood pressure is >160mmHg., Post-op
<input type="checkbox"/> Remove sheath	Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
<input type="checkbox"/> The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op
<input type="checkbox"/> Place/Maintain Sequential Compression Device following Manufacturer Insert/instructions.	Routine, Continuous Follow manufacturer insert/instructions for use, physician orders, or Progressive Cuff Deflation instruction specific to Diagnostic or Interventional Procedure performed. Radial Band, Post-op
<input type="checkbox"/> Progressive cuff deflation (Single Response) (Selection Required)	
<input type="checkbox"/> Diagnostic Procedures only (Selection Required)	

<input type="checkbox"/> 30 minutes after Radial Compression Device applied	Routine, Until discontinued, Starting S deflate 3cc of air from cuff. If no bleeding occurs from site, deflate 3cc of air from the Radial Compression Device every 5 minutes until all air is completely removed. If bleeding occurs when 3cc of air is removed, re-inflate with 3cc of air. Wait 15 minutes, then restart releasing 3cc of air every 5 minutes until all air is completely removed. If site remains free of bleeding/hematoma after 5 min, remove TR band, apply dressing., Post-op
<input type="checkbox"/> Monitor access site and extremity distal to puncture wound	Routine, Until discontinued, Starting S every 15 minutes until Radial Compression Device is removed., Post-op
<input type="checkbox"/> Assess for absence of ulnar pulse, capillary refill greater than 3 seconds, cyanosis, numbness and/or pain in affected extremity.	Routine, Until discontinued, Starting S, If any of these are present, notify the procedural Cardiologist.
() Interventional Procedures only (Selection Required)	
<input type="checkbox"/> 2 hours after Radial Compression Device applied deflate 3cc	Routine, Until discontinued, Starting S if no bleeding at site, deflate 3cc every 10 min until all air removed from cuff. If bleeding occurs when 3cc of air is removed, re-inflate with 3cc of air. Wait 30 minutes then restart releasing 3cc of air every 10 minutes until all air has been removed. If site remains free of bleeding/hematoma after 5 min, remove TR band, apply dressing., Post-op
<input type="checkbox"/> Evaluate access site for bleeding as follows:	Routine, Until discontinued, Starting S every 15 minutes x 4; every 30 minutes x2; and every hour x2., Post-op
<input type="checkbox"/> Patient Education Prior to Sheath Removal and Hospital Discharge	
<input type="checkbox"/> Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify), Activity Specify: Patient education prior to post sheath removal. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op
<input type="checkbox"/> Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify), Activity, Discharge, Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op
<input type="checkbox"/> Pre-Sheath Removal	
<input type="checkbox"/> Vital signs prior to sheath removal	Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, include verified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, check every 4 hours., Post-op
<input type="checkbox"/> Assist patient to void	Routine, Once For 1 Occurrences Assist patient to void prior to sheath removal., Post-op
<input type="checkbox"/> Assess pre-sheath cath site	Routine, Once For 1 Occurrences Assess for signs and symptoms of hematoma or other vascular compromise distal to site on arrival unless otherwise ordered by the physician. If hematoma is present, mark on skin surface and complete hematoma documentation., Post-op
<input type="checkbox"/> Patient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op

<input type="checkbox"/>	Apply hemostatic patch after assessment for hematoma, distal pulses.	Routine, Until discontinued, Starting S Apply pressure proximal to site, place patch over site, slowly remove sheath, allow blood to moisten patch. Apply direct pressure to site/proximal pressure for ½ allotted time. Slowly release proximal pressure, continue direct pressure over the site for a minimum of 20 minutes for PCI/10 minutes for diagnostic cath., Post-op
<input type="checkbox"/>	Antegrade sheaths present	Routine, Until discontinued, Starting S Antegrade sheath must be pulled by Physicians or appropriately trained staff in the Cath Lab setting., Post-op
<input type="checkbox"/> Post-Sheath Removal (Selection Required)		
<input type="checkbox"/>	Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/>	Peripheral vascular assessment - Monitor access site	Routine, Every 15 min Monitor access site, extremity distal to puncture every 15 min until Radial approach cath band removed., Post-op
<input type="checkbox"/>	Notify physician of bleeding and/or loss of pulses.	Routine, Until discontinued, Starting S, Notify physician of bleeding and/or loss of pulses., Post-op
<input type="checkbox"/>	Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
<input type="checkbox"/>	No blood pressure readings, lab draws, or IV access	Routine, Until discontinued, Starting S No blood pressure readings, lab draws, or IV access in the affected arm for 24 hours., Post-op
<input type="checkbox"/>	Limit movement in affected arm 6 hrs post procedure	Routine, Until discontinued, Starting S keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs. If needed, place wrist on arm board to restrict movement., Post-op
<input type="checkbox"/>	Patient may ambulate 30 minutes after arrival in recovery area.	Routine, Until discontinued, Starting S Specify: Other activity (specify) Other: Patient may ambulate 30 minutes after arrival in recovery area. Post-op
<input type="checkbox"/>	Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
<input type="checkbox"/>	Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/> Manual Pressure - without Radial Compression Device		
<input type="checkbox"/>	The physician must be notified prior to sheath removal of a systolic blood if pressure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal of a systolic blood if pressure >160mmHg., Post-op
<input type="checkbox"/>	Remove sheath	Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
<input type="checkbox"/>	The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op
<input type="checkbox"/>	Patient Education Prior to Sheath Removal and Hospital Discharge	

<input type="checkbox"/>	Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify), Activity Specify: Patient education prior to post sheath removal. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op
<input type="checkbox"/>	Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify), Activity, Discharge, Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op
<input type="checkbox"/> Pre-Sheath Removal		
<input type="checkbox"/>	Vital signs prior to sheath removal	Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, include verified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, check every 4 hours., Post-op
<input type="checkbox"/>	Assist patient to void	Routine, Once For 1 Occurrences Assist patient to void prior to sheath removal., Post-op
<input type="checkbox"/>	Assess pre-sheath cath site	Routine, Once For 1 Occurrences Assess for signs and symptoms of hematoma or other vascular compromise distal to site on arrival unless otherwise ordered by the physician. If hematoma is present, mark on skin surface and complete hematoma documentation., Post-op
<input type="checkbox"/>	Patient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op
<input type="checkbox"/>	Apply hemostatic patch after assessment for hematoma, distal pulses.	Routine, Until discontinued, Starting S Apply pressure proximal to site, place patch over site, slowly remove sheath, allow blood to moisten patch. Apply direct pressure to site/proximal pressure for ½ allotted time. Slowly release proximal pressure, continue direct pressure over the site for a minimum of 20 minutes for PCI/10 minutes for diagnostic cath., Post-op
<input type="checkbox"/>	Antegrade sheaths present	Routine, Until discontinued, Starting S Antegrade sheath must be pulled by Physicians or appropriately trained staff in the Cath Lab setting., Post-op
<input type="checkbox"/> Post-Sheath Removal		
<input type="checkbox"/>	Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/>	Notify physician of bleeding and/or loss of pulses.	Routine, Until discontinued, Starting S, Notify physician of bleeding and/or loss of pulses., Post-op
<input type="checkbox"/>	Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
<input type="checkbox"/>	No blood pressure readings, lab draws, or IV access	Routine, Until discontinued, Starting S No blood pressure readings, lab draws, or IV access in the affected arm for 24 hours., Post-op
<input type="checkbox"/>	Limit movement in affected arm 6 hrs post procedure	Routine, Until discontinued, Starting S keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs. If needed, place wrist on arm board to restrict movement., Post-op

<input type="checkbox"/> Patient may ambulate 30 minutes after arrival in recovery area.	Routine, Until discontinued, Starting S Specify: Other activity (specify) Other: Patient may ambulate 30 minutes after arrival in recovery area. Post-op
<input type="checkbox"/> Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
<input type="checkbox"/> Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op

Femoral - Sheath Removal

<input type="checkbox"/> Closure Devices	
<input type="checkbox"/> The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op
<input type="checkbox"/> Activity (Selection Required)	
<input type="checkbox"/> Patient was treated with a closure device.	Routine, Until discontinued, Starting S Bedrest required minimum of *** hours. Keep affected leg straight., Post-op
<input type="checkbox"/> Patient Education Prior to Sheath Removal and Hospital Discharge	
<input type="checkbox"/> Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify), Activity Specify: Patient education prior to post sheath removal. Sign and symptoms, Post-op
<input type="checkbox"/> Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify), Activity, Discharge, Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op
<input type="checkbox"/> Post Procedure Assessment	
<input type="checkbox"/> Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/> Assess post-sheath cath site	Routine, Every 15 min For Until specified Assess site for signs and symptoms of a hematoma or other vascular compromise distal to site Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/> Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
<input type="checkbox"/> Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op

<input type="checkbox"/>	Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/> Manual Pressure		
<input type="checkbox"/>	The physician must be notified prior to sheath removal of a systolic blood if pressure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal if systolic blood pressure is >160mmHg., Post-op
<input type="checkbox"/>	Remove sheath	Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
<input type="checkbox"/>	The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op
<input type="checkbox"/> Activity (Selection Required)		
<input type="checkbox"/>	Bed rest times following Procedure using femoral artery access are: (Must Select One) (Single Response) (Selection Required)	
<input type="checkbox"/>	Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/>	Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 3 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/>	Patient was treated with a 6 French catheter. Minimum 20 minutes for PCI/15 minutes of pressure at site for Diagnostic/Bedrest required minimum of 4 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/>	Patient was treated with a 7 French or greater catheter. Minimum 25 minutes of pressure at site/Bedrest required minimum of *** hours.	Routine, Until discontinued, Starting S Bedrest required minimum of *** hours. Keep affected leg straight. Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/> Patient Education Prior to Sheath Removal and Hospital Discharge		
<input type="checkbox"/>	Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify), Activity Specify: Patient education prior to post sheath removal. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op
<input type="checkbox"/>	Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify), Activity, Discharge, Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op
<input type="checkbox"/> Pre-Sheath Removal		

<input type="checkbox"/>	Vital signs prior to sheath removal	Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, include verified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, check every 4 hours., Post-op
<input type="checkbox"/>	Assist patient to void	Routine, Once For 1 Occurrences Assist patient to void prior to sheath removal., Post-op
<input type="checkbox"/>	Assess pre-sheath cath site	Routine, Once For 1 Occurrences Assess for signs and symptoms of hematoma or other vascular compromise distal to site on arrival unless otherwise ordered by the physician. If hematoma is present, mark on skin surface and complete hematoma documentation., Post-op
<input type="checkbox"/>	Patient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op
<input type="checkbox"/>	Apply hemostatic patch after assessment for hematoma, distal pulses.	Routine, Until discontinued, Starting S Apply pressure proximal to site, place patch over site, slowly remove sheath, allow blood to moisten patch. Apply direct pressure to site/proximal pressure for ½ allotted time. Slowly release proximal pressure, continue direct pressure over the site for a minimum of 20 minutes for PCI/10 minutes for diagnostic cath., Post-op
<input type="checkbox"/>	Antegrade sheaths present	Routine, Until discontinued, Starting S Antegrade sheath must be pulled by Physicians or appropriately trained staff in the Cath Lab setting., Post-op
<input type="checkbox"/>	Post-Sheath Removal	
<input type="checkbox"/>	Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/>	Assess post-sheath cath site	Routine, Every 15 min For Until specified Assess site for signs and symptoms of a hematoma or other vascular compromise distal to site Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/>	Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
<input type="checkbox"/>	Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
<input type="checkbox"/>	Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/>	Compression Systems (Single Response)	
<input type="checkbox"/>	() C-clamp (Selection Required)	
<input type="checkbox"/>	The physician must be notified prior to sheath removal of a systolic blood if pressure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal of a systolic blood if pressure >160mmHg., Post-op
<input type="checkbox"/>	Remove sheath	Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
<input type="checkbox"/>	The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, for abnormal vital signs, uncontrolled pain, absence of pulses/limb discoloration, bleeding, hematoma formation, or signs of complications., Post-op
<input type="checkbox"/>	Activity Post Sheath Removal-Femoral Approach (Selection Required)	

<input type="checkbox"/> Bed rest times following Procedure using femoral artery access are: (Must Select One) (Single Response) (Selection Required)	
<input type="checkbox"/> Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/> Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 3 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/> Patient was treated with a 6 French catheter. Minimum 20 minutes for PCI/15 minutes of pressure at site for Diagnostic/Bedrest required minimum of 4 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/> Patient was treated with a 7 French or greater catheter. Minimum 25 minutes of pressure at site/Bedrest required minimum of *** hours.	Routine, Until discontinued, Starting S Bedrest required minimum of *** hours. Keep affected leg straight. Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/> Patient Education Prior to Sheath Removal and Hospital Discharge	
<input type="checkbox"/> Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify),Activity Specify: Patient education prior to post sheath removal. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op
<input type="checkbox"/> Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify),Activity,Discharge,Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op
<input type="checkbox"/> Pre-Sheath Removal	
<input type="checkbox"/> Vital signs prior to sheath removal	Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, include verified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, check every 4 hours., Post-op
<input type="checkbox"/> Assist patient to void	Routine, Once For 1 Occurrences Assist patient to void prior to sheath removal., Post-op
<input type="checkbox"/> Assess pre-sheath cath site	Routine, Once For 1 Occurrences Assess for signs and symptoms of hematoma or other vascular compromise distal to site on arrival unless otherwise ordered by the physician. If hematoma is present, mark on skin surface and complete hematoma documentation., Post-op
<input type="checkbox"/> Patient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op

<input type="checkbox"/>	Apply hemostatic patch after assessment for hematoma, distal pulses.	Routine, Until discontinued, Starting S Apply pressure proximal to site, place patch over site, slowly remove sheath, allow blood to moisten patch. Apply direct pressure to site/proximal pressure for ½ allotted time. Slowly release proximal pressure, continue direct pressure over the site for a minimum of 20 minutes for PCI/10 minutes for diagnostic cath., Post-op
<input type="checkbox"/>	Antegrade sheaths present	Routine, Until discontinued, Starting S Antegrade sheath must be pulled by Physicians or appropriately trained staff in the Cath Lab setting., Post-op
<input type="checkbox"/> Post-Sheath Removal		
<input type="checkbox"/>	Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/>	Assess post-sheath cath site	Routine, Every 15 min For Until specified Assess site for signs and symptoms of a hematoma or other vascular compromise distal to site Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/>	Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
<input type="checkbox"/>	Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
<input type="checkbox"/>	Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/> Femostop		
<input type="checkbox"/>	The physician must be notified prior to sheath removal of a systolic blood if pressure >160mmHg.	Routine, Until discontinued, Starting S, prior to sheath removal of a systolic blood if pressure >160mmHg., Post-op
<input type="checkbox"/>	Remove sheath	Routine, Once For 1 Occurrences when ACT less than 160 or within physician specified parameters. Sheath may be removed 2 hours after discontinuation of Angiomax (Bivalirudin) infusion unless otherwise specified by physician order., Post-op
<input type="checkbox"/>	The physician must be notified for any signs of complications.	Routine, Until discontinued, Starting S, capillary refill > 3 seconds, cyanosis, numbness and/or pain in affected extremity, bleeding, hematoma formation, or signs of complication., Post-op
<input type="checkbox"/>	Follow Femostop manufacturer's guidelines in package insert.	Routine, Until discontinued, Starting S, Post-op
<input type="checkbox"/> Activity Post Sheath Removal-Femoral Approach (Selection Required)		
<input type="checkbox"/> Bed rest times following Procedure using femoral artery access are: (Must Select One) (Single Response) (Selection Required)		
<input type="checkbox"/>	Patient was treated with a 4 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 2 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/>	Patient was treated with a 5 French catheter. Minimum 15 minutes of pressure at site/Bedrest required minimum of 3 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op

<input type="checkbox"/> Patient was treated with a 6 French catheter. Minimum 20 minutes for PCI/15 minutes of pressure at site for Diagnostic/Bedrest required minimum of 4 hours.	Routine, Until discontinued, Starting S Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/> Patient was treated with a 7 French or greater catheter. Minimum 25 minutes of pressure at site/Bedrest required minimum of *** hours.	Routine, Until discontinued, Starting S Bedrest required minimum of *** hours. Keep affected leg straight. Patient may bend unaffected leg. Use urinal or bedpan as needed., Post-op
<input type="checkbox"/> Patient Education Prior to Sheath Removal and Hospital Discharge	
<input type="checkbox"/> Patient education prior to post-sheath removal	Routine, Once, Starting S For 1 Occurrences Patient/Family: Patient Education for: Other (specify),Activity Specify: Patient education prior to post sheath removal. Provide patient post-sheath removal instructions to include reports of warmth, moistness, swelling, numbness or pain at insertion site., Post-op
<input type="checkbox"/> Patient education prior to discharge	Routine, Prior to discharge, Starting S Patient/Family: Patient Education for: Other (specify),Activity,Discharge,Smoking cessation counseling Specify: Patient education prior to discharge. Provide discharge instruction on emergent physician contact/symptom reporting due to bleeding/hematoma/swelling/pain/tenderness/numbness/tingling, Activity and Limitations and site care. Activity including Limiting movement in affected arm 6 hrs post procedure and keep wrist straight , refrain from lifting or pushing with the affected arm for 48 hrs., and site care., Post-op
<input type="checkbox"/> Pre-Sheath Removal	
<input type="checkbox"/> Vital signs prior to sheath removal	Routine, Every 15 min Vital signs prior to sheath removal - Obtain base line vital signs, include verified ACT results of less than 160 or within parameters ordered by physician, unless otherwise ordered by the physician. For Temp, check every 4 hours., Post-op
<input type="checkbox"/> Assist patient to void	Routine, Once For 1 Occurrences Assist patient to void prior to sheath removal., Post-op
<input type="checkbox"/> Assess pre-sheath cath site	Routine, Once For 1 Occurrences Assess for signs and symptoms of hematoma or other vascular compromise distal to site on arrival unless otherwise ordered by the physician. If hematoma is present, mark on skin surface and complete hematoma documentation., Post-op
<input type="checkbox"/> Patient transferred with sheaths left in place	Routine, Until discontinued, Starting S Patient transferred with Sheaths left in place., Post-op
<input type="checkbox"/> Apply hemostatic patch after assessment for hematoma, distal pulses.	Routine, Until discontinued, Starting S Apply pressure proximal to site, place patch over site, slowly remove sheath, allow blood to moisten patch. Apply direct pressure to site/proximal pressure for ½ allotted time. Slowly release proximal pressure, continue direct pressure over the site for a minimum of 20 minutes for PCI/10 minutes for diagnostic cath., Post-op
<input type="checkbox"/> Antegrade sheaths present	Routine, Until discontinued, Starting S Antegrade sheath must be pulled by Physicians or appropriately trained staff in the Cath Lab setting., Post-op
<input type="checkbox"/> Post-Sheath Removal	
<input type="checkbox"/> Vital signs after sheath removal	Routine, Every 15 min For Until specified Assess/document vital signs Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op

<input type="checkbox"/> Assess post-sheath cath site	Routine, Every 15 min For Until specified Assess site for signs and symptoms of a hematoma or other vascular compromise distal to site Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op
<input type="checkbox"/> Site care	Routine, Once Site: catheter site Ensure complete hemostasis at catheter site, palpate for hematoma, apply appropriate dressing. At a minimum, cover site with 2X2 gauze and transparent dressing., Post-op
<input type="checkbox"/> Assess for pulse distal to assess site post-sheath removal	Routine, Every 15 min For Until specified Pulses to assess: Distal Side: Assess and document Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q 4 hours x4 unless otherwise ordered by physician., Post-op
<input type="checkbox"/> Neurological assessment after sheath removal	Routine, Every 15 min For Until specified Assessment to Perform: Assess/document neurological assessment Q 15 min x4, Q 30 min x4, Q 1 hour x4, and Q4 x4 unless otherwise ordered by the physician., Post-op

Diet

<input type="checkbox"/> NPO (for 1 hour)	Diet effective now, Starting S For 1 Hours NPO: Pre-Operative fasting options: Post-op
<input type="checkbox"/> Diet	Diet effective now, Starting S Diet(s): Other Options: Advance Diet as Tolerated? IDDSI Liquid Consistency: Fluid Restriction: Foods to Avoid: Foods to Avoid: Post-op
<input type="checkbox"/> Tube feeding	Diet effective now, Starting S Tube Feeding Formula: Tube Feeding Formula: Tube Feeding Formula: Tube Feeding Formula: Tube Feeding Formula: Tube Feeding Formula: Tube Feeding Formula: Tube Feeding Formula: Tube Feeding Schedule: Tube Feeding Schedule: Dietitian to manage Tube Feed? Post-op

IV Fluids

IV Fluids

<input type="checkbox"/> sodium chloride 0.45 % infusion	1,000 mL, intravenous, for 10 Hours, continuous, Post-op
<input type="checkbox"/> sodium chloride 0.9 % infusion	1,000 mL, intravenous, for 10 Hours, continuous, Post-op
<input type="checkbox"/> dextrose 5%-0.45% sodium chloride infusion	intravenous, for 10 Hours, continuous, Post-op
<input type="checkbox"/> dextrose 5%-0.9% sodium chloride infusion	intravenous, for 10 Hours, continuous, Post-op

Post-Procedure Hydration (Single Response)

<input type="checkbox"/> Inpatient (Single Response)	
<input type="checkbox"/> Patients with EF LESS than 40% or with evidence of fluid overload	0.5 mL/kg/hr, intravenous, continuous Infuse for 6 hours Post-Procedure

<input type="checkbox"/> Patients with EF GREATER than 40% or no evidence of fluid overload	1 mL/kg/hr, intravenous, continuous Infuse for 6 hours Post-Procedure
<input type="checkbox"/> Outpatient (Single Response)	
<input type="checkbox"/> Patients with EF LESS than 40% or with evidence of fluid overload	0.5 mL/kg/hr, intravenous, continuous Infuse for 6 hours Post-Procedure or until discharge, whichever comes first.
<input type="checkbox"/> Patients with EF GREATER than 40% or no evidence of fluid overload	1 mL/kg/hr, intravenous, continuous Infuse for 6 hours Post-Procedure or until discharge, whichever comes first.

Medications

Anti-Platelet Agents

<input type="checkbox"/> aspirin (ECOTRIN) enteric coated tablet	325 mg, oral, daily, Post-op
<input type="checkbox"/> aspirin (ECOTRIN) enteric coated tablet	81 mg, oral, daily, Post-op
<input type="checkbox"/> clopidogrel (PLAVIX) tablet	75 mg, oral, daily, Post-op

Post-Procedure Medications

<input type="checkbox"/> hydroMORPHone (DILAUDID) or fentaNYL (SUBLIMAZE) injection (Single Response)	
<input type="checkbox"/> fentaNYL (SUBLIMAZE) injection	25 mcg, intravenous, every 15 min PRN, severe pain (score 7-10), For 2 Doses, PACU & Post-op Hold for respirations LESS than 12 breath/minute. For persistent pain, call interventional MD.
<input type="checkbox"/> hydromorPHONE (DILAUDID) injection	0.5 mg, intravenous, every 15 min PRN, severe pain (score 7-10), For 2 Doses, PACU & Post-op Hold for respirations LESS than 12 breath/minute. For persistent pain, call interventional MD.
<input checked="" type="checkbox"/> naloxone (NARCAN) 0.4 mg/mL injection	0.2 mg, intravenous, once PRN, opioid reversal, PACU & Post-op
<input type="checkbox"/> ondansetron (ZOFTRAN) IV	4 mg, intravenous, once PRN, nausea, vomiting, PACU & Post-op

Insomnia Agents (Single Response)

<input type="checkbox"/> zolpidem (AMBIEN) tablet	5 mg, oral, nightly PRN, sleep, Post-op
<input type="checkbox"/> temazepam (RESTORIL) capsule	15 mg, oral, nightly PRN, sleep, Post-op Indication(s): Insomnia
<input type="checkbox"/> ramelteon (ROZEREM) tablet	8 mg, oral, nightly PRN, sleep, Post-op

Insomnia Agents - for patient GREATER than 70 years old (Single Response)

<input type="checkbox"/> ramelteon (ROZEREM) tablet	8 mg, oral, nightly PRN, sleep, Post-op
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Labs

Labs in 4 Hours

<input type="checkbox"/> Basic metabolic panel	Once In 4 hr., Post-op
<input type="checkbox"/> Lipid panel	Once In 4 hr., Post-op
<input type="checkbox"/> Prothrombin time with INR	Once In 4 hr., Post-op
<input type="checkbox"/> CBC with differential	Once In 4 hr., Post-op

Labs Tomorrow

<input type="checkbox"/> Basic metabolic panel	AM draw For 1 Occurrences, Post-op
<input type="checkbox"/> Prothrombin time with INR	AM draw For 1 Occurrences, Post-op
<input type="checkbox"/> CBC with differential	AM draw For 1 Occurrences, Post-op
<input type="checkbox"/> Lipid panel	AM draw For 1 Occurrences, Post-op

Cardiology

Diagnostic Imaging

Other Diagnostic Studies

Respiratory

Rehab

Consults

Additional Orders

Discharge

Discharge Order (Single Response)

- | | |
|--|---|
| <input type="checkbox"/> Discharge patient when criteria met | Routine, Once
Discharge Criteria:
Clearing specialty:
Scheduling/ADT |
| <input type="checkbox"/> Discharge to home | Routine, Once
Discharge Criteria:
Clearing specialty:
Scheduling/ADT |

Discontinue tubes/drains

- | | |
|--|---|
| <input type="checkbox"/> Discontinue Foley catheter | Routine, Once, Scheduling/ADT |
| <input type="checkbox"/> Discharge home with Foley catheter | Routine, Once, Scheduling/ADT |
| <input type="checkbox"/> Discontinue IV | Routine, Once For 1 Occurrences, Scheduling/ADT |
| <input type="checkbox"/> Deaccess port | |
| <input type="checkbox"/> Deaccess Port-a-cath | Routine, Once, Scheduling/ADT |
| <input type="checkbox"/> heparin, porcine (PF) 100 unit/mL injection | intra-catheter, once, Scheduling/ADT |

Discharge Activity

- | | |
|---|--|
| <input type="checkbox"/> Activity as tolerated | Routine, Normal, Scheduling/ADT |
| <input type="checkbox"/> Ambulate with assistance or assistive device | Routine, Normal, Scheduling/ADT |
| <input type="checkbox"/> Lifting restrictions | Routine, Normal, Scheduling/ADT, No lifting over 10 pounds. |
| <input type="checkbox"/> Weight bearing restrictions (specify) | Routine, Normal, Scheduling/ADT
Weight Bearing Status:
Extremity:
*** |
| <input type="checkbox"/> Moderate bedrest with complete pelvic rest (no tampons, douching, sex) | Routine, Normal, Scheduling/ADT |
| <input type="checkbox"/> Complete pelvic rest (no tampons, douching, sex) | Routine, Normal, Scheduling/ADT |
| <input type="checkbox"/> No driving for 2 weeks | Routine, Normal, Scheduling/ADT |
| <input type="checkbox"/> Shower instructions: | Routine, Normal, Scheduling/ADT, *** |
| <input type="checkbox"/> Discharge activity | Routine, Normal, Scheduling/ADT |
| <input type="checkbox"/> Other restrictions (specify): | Routine, Normal, Scheduling/ADT, *** |

Wound/Incision Care

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Discharge wound care | Routine, Normal, Scheduling/ADT, *** |
| <input type="checkbox"/> Discharge incision care | Routine, Normal, Scheduling/ADT, *** |
| <input type="checkbox"/> Discharge dressing | Routine, Normal, Scheduling/ADT, *** |

Discharge Diet - REQUIRED (Single Response)

- | | |
|---|--|
| <input type="checkbox"/> Discharge Diet | Routine, Normal, Scheduling/ADT
Discharge Diet: |
|---|--|

<input type="checkbox"/> Discharge Diet- Regular	Routine, Normal, Scheduling/ADT Discharge Diet: Regular
Patient to notify physician	
<input type="checkbox"/> Call physician for:	Routine, Normal, Scheduling/ADT, Temperature greater than 100.5
<input type="checkbox"/> Call physician for: Persistent nausea or vomiting	Routine, Normal, Scheduling/ADT
<input type="checkbox"/> Call physician for: severe uncontrolled pain	Routine, Normal, Scheduling/ADT
<input type="checkbox"/> Call physician for: redness, tenderness, or signs of infection (pain, swelling, redness, odor or green/yellow discharge from affected area)	Routine, Normal, Scheduling/ADT
<input type="checkbox"/> Call physician for difficulty breathing, chest pain, persistent dizziness or light-headedness	Routine, Normal, Scheduling/ADT
<input type="checkbox"/> Call physician for:	Routine, Normal, Scheduling/ADT, ***
Discharge Education	
<input type="checkbox"/> Nurse to provide discharge education	Routine, Once Patient/Family: Both Education for: Other (specify) Specify: Nurse to provide patient education Scheduling/ADT
<input type="checkbox"/> Nurse to provide tobacco cessation education	Routine, Once Patient/Family: Both Education for: Other (specify) Specify: Nurse to provide tobacco cessation education Scheduling/ADT
Discharge Instructions	
<input type="checkbox"/> Additional discharge instructions for Patient	Routine, Normal, Scheduling/ADT, ***
<input type="checkbox"/> Discharge instructions for Nursing- Will not show on AVS	Routine, Once ***, Scheduling/ADT
Place Follow-Up Order	
<input type="checkbox"/> Follow-up with me	Follow up with me: Clinic Contact: Follow up in: On date: Appointment Time:
<input type="checkbox"/> Follow-up with primary care physician	Routine, Normal, Scheduling/ADT
<input type="checkbox"/> Follow-up with physician	Follow up on: Appointment Time: Follow up in: Instructions for Follow Up:
<input type="checkbox"/> Follow-up with physician	Follow up on: Appointment Time: Follow up in: Instructions for Follow Up:
<input type="checkbox"/> Follow-up with department	Details