Location: _____

General

Nursing

Consent

☐ **Complete consent for** **Frequency:** Once **Start Date:** S **Priority:** Routine **Comments:** Right heart catheterization and biopsy. Indication: Heart allograft dysfunction
Question(s):
Procedure: ○ Right heart catheterization and biopsy
Diagnosis/Condition: ○ Indication: Heart allograft dysfunction
Physician:
Risks, benefits, and alternatives (as outlined by the Texas Medical Disclosure Panel, as appears on Houston Methodist Medical/Surgical Consent forms) were discussed with patient/surrogate?

☐ **Complete consent for** **Frequency:** Once **Priority:** Routine **Comments:** Left heart catheterization Indication: Heart allograft dysfunction
Question(s):
Procedure: ○ Left heart catheterization
Diagnosis/Condition: ○ Indication: Heart allograft dysfunction
Physician:
Risks, benefits, and alternatives (as outlined by the Texas Medical Disclosure Panel, as appears on Houston Methodist Medical/Surgical Consent forms) were discussed with patient/surrogate?

IV Fluids

Medications

IV Steriods

○ **methylPREDNISolone (Solu-MEDROL) IV** **Route:** intravenous **Frequency:** daily
Admin Instructions:
If given by IV Push, administer over no less than 3 minutes.

Premedications

☐ **acetaminophen (TYLENOL) tablet** **Dose:** 650 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give 30 minutes PRIOR to Antithymocyte Globulin infusion.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

☐ **Premedication: diphenhydramine (BENADRYL) tablet OR injection**

◉ **diphenhydrAMINE (BENADRYL) tablet** **Dose:** 25 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Give 30 minutes PRIOR to Antithymocyte Globulin infusion.

◉ **diphenhydrAMINE (BENADRYL) injection** **Dose:** 25 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Give 30 minutes PRIOR to Antithymocyte Globulin infusion.

☐ **Premedications: Steroids**

○ **methylPREDNISolone sodium succinate (Solu-MEDROL) injection** **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Give 1 hour PRIOR to Antithymocyte Globulin infusion.

○ **hydrocortisone sodium succinate (Solu-CORTEF) injection** **Dose:** 100 **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Give 30 minutes PRIOR to Antithymocyte Globulin infusion.

Antithymocyte Immune Globulin

☐ **antithymocyte globulin (rabbit) (THYMOGLOBULIN) 1.5 mg/kg in sodium chloride 0.9 % 250 mL IVPB** **Dose:** 1.5 mg/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Product Admin Instructions:
Administer via 0.2 micron low protein binding filter into a CENTRAL line

Infusion Reation Management

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☐ **hydrocortisone sodium succinate (Solu-CORTEF) injection** **Dose:** 100 mg **Route:** intravenous **Frequency:** once PRN **PRN Comment:** chills

☐ **acetaminophen (TYLENOL) tablet** **Dose:** 325 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Comment:** for Temperature GREATER than 100 F **PRN Reasons:** fever
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

Labs

Laboratory

☐ **NT-proBNP** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Troponin T** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **C1q complement component** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

☐ **HLA antibody screen - post transplant** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Collect 1 Red Top tube (6 mL)

{HLAA Post Options:29256}

Cardiology

Cardiology

☐ **Echocardiogram complete w contrast and 3D if needed** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT **Comments:** STAT; To assess LV Function.
Question(s):
Does this study require a chemo toxicity strain protocol?
Does this exam need a strain protocol?
Call back number for Critical Findings:
Where should test be performed?
Does this exam need a bubble study?
Preferred interpreting Cardiologist or group:
Process Instructions:
If this patient has had an echocardiogram ordered/performed within the past 120 hours as indicated by repeat Echo orders report on the left. Please contact the Echo department at 713-441-2222 to discuss the reason for a repeat exam with a cardiologist.

For STAT order, select appropriate STAT Indication. Please enter the cell phone number for the ordering physician so the echo attending can communicate the results of the stat test promptly. If the phone number is not entered, we will not be able to perform the test as stat. Please note that nursing unit phone number or NP phone number do not meet this request'

Other Indications should be ordered for TODAY or Routine.

For Discharge or Observation patient, please choose TODAY as Priority.

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☐ **Echocardiogram complete w contrast and 3D if needed** **Frequency:** 1 time imaging **Priority:** Routine **Comments:** ASAP; To assess LV Function.
Question(s):
Does this study require a chemo toxicity strain protocol?
Does this exam need a strain protocol?
Call back number for Critical Findings:
Where should test be performed?
Does this exam need a bubble study?
Preferred interpreting Cardiologist or group:
Process Instructions:
If this patient has had an echocardiogram ordered/performed within the past 120 hours as indicated by repeat Echo orders report on the left. Please contact the Echo department at 713-441-2222 to discuss the reason for a repeat exam with a cardiologist.

For STAT order, select appropriate STAT Indication. Please enter the cell phone number for the ordering physician so the echo attending can communicate the results of the stat test promptly. If the phone number is not entered, we will not be able to perform the test as stat. Please note that nursing unit phone number or NP phone number do not meet this request'

Other Indications should be ordered for TODAY or Routine.

For Discharge or Observation patient, please choose TODAY as Priority.

Imaging
Other Studies
Respiratory
Rehab
Consults
For Physician Consult orders use sidebar
Additional Orders

Sign:_____ **Printed Name:**_____ **Date/Time:**_____