attach patient label

# Physician Orders

**LEB CARD Cath Lab/IR Pre Procedure Plan**

**[X or R]** = will be ordered unless marked out.

**PEDIATRIC**

**Height: _____cm Weight: _____kg**

| | | |
|---|---|---|
| **Allergies:** | | |
| [ ] No known allergies | | |
| **[ ]** | Initiate Powerplan Phase | T;N |
| **Admission/Transfer/Discharge** | | |
| **[ ]** | Admit Patient to Dr. _____ | |
| **[ ]** | **Admit Status:** [ ] Inpatient [ ] Routine Post Procedure <24hrs [ ] 23 hour OBS | |
| **[ ]** | **Bed Type:** [ ] Med/Surg [ ] Critical Care [ ] Stepdown [ ] Telemetry; Specific Unit Location: ____ | |
| **[ ]** | Admit Patient | T;N |
| **[ ]** | Notify Physician Once | T;N, of room number on arrival to unit |
| Primary Diagnosis:_____ | | |
| Secondary Diagnosis: _____ | | |
| **Vital Signs** | | |
| **[ ]** | Vital Signs | T;N, Routine Monitor and Record T,P,R,BP |
| **Food/Nutrition** | | |
| **[ ]** | NPO | Start at: T;N |
| **Patient Care** | | |
| **[ ]** | Consent Signed For | T;N, Procedure:_____ |
| **[ ]** | Height | T;N |
| **[ ]** | Weight | T;N |
| **[ ]** | Cardiopulmonary Monitor | T;N Routine, Monitor Type: CP Monitor |
| **[ ]** | O2 Sat Spot Check (NSG) | T;N, q8h, with vital signs |
| **[ ]** | O2 Sat Monitoring (NSG) | T;N, q2h(std) |
| **[ ]** | Nursing Communication | T;N, If patient is female, equal to or greater than 10 years of age and not currently on cycle, place order for Pregnancy Screen Serum if a Pregnancy Screen is not already ordered. |
| **Respiratory Care** | | |
| **[ ]** | Oxygen Delivery | T;N, ____L/min, Titrate to keep O2 sat =/> 70% |
| **[ ]** | Oxygen Delivery | T;N, ____L/min, Titrate to keep O2 sat =/> 80% |
| **[ ]** | Oxygen Delivery | T;N, ____L/min, Titrate to keep O2 sat =/> 90% |
| **Medications** | | |
| **[ ]** | ceFAZolin | _____ mg, (25 mg/kg), Injection, IV, N/A, (for 1 dose), STAT, T;N, Pharmacy to send to cath lab, Max dose = 1 gram |
| **[ ]** | vancomycin | _____ mg, (10 mg/kg),Injection, IV, N/A, (for 1 dose), STAT, T;N, Pharmacy to send to cath lab, Max dose = 1 gram |

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| | | |
|---|---|---|
| **Laboratory** | | |
| **[ ]** | **LEB Transfusion-Less than 4 Months of Age Plan** | **see separate sheet** |
| **[ ]** | **LEB Transfusion- 4 Months of Age or Greater Plan** | **see separate sheet** |
| [ ] | CBC | STAT, T;N, once, Type: Blood |
| [ ] | Hematocrit & Hemoglobin | STAT, T;N, once, Type: Blood, Collection Comment: to be drawn in Cath Lab |
| [ ] | Comprehensive Metabolic Panel (CMP) | STAT, T;N, once, Type: Blood |
| [ ] | Basic Metabolic Panel ( BMP ) | STAT, T;N, once, Type: Blood |
| [ ] | Prothrombin Time ( PT/INR ) | STAT, T;N, once, Type: Blood |
| [ ] | Partial Thromboplastin Time ( PTT ) | STAT, T;N, once, Type: Blood |
| [ ] | Pregnancy Screen Serum | STAT, T;N, once, Type: Blood |
| [ ] | Pregnancy Screen Urine | STAT, T;N, once, Type: Urine, Nurse Collect |
| [ ] | Urinalysis w/Reflex Microscopic Exam | STAT, T;N, once, Type: Urine, Nurse Collect |
| **Diagnostic Tests** | | |
| [ ] | Chest 2VW Frontal & Lat | T;N, STAT, Reason: Other, enter in comments, Transport: Wheelchair Order Comment: Congenital Heart Disease |
| [ ] | Electrocardiogram (EKG ) | T;N, STAT, Reason: other specify, Congential Heart Disease, Bedside |
| [ ] | Echo Pediatric (0-18 years) | T;N, STAT, Reason: Congential Heart Disease,Special Instructions: Intra-Cardiac ECHO, Perform during cath procedure |
| [ ] | Echo Pediatric (0-18 years) | T;N, STAT, Reason: Congential Heart Disease, Special Instructions: Transthoracic ECHO, Perform during cath procedure |
| [ ] | TEE Pediatric 0-18 | T;N, STAT, Reason: Congential Heart Disease, Special Instructions: Perform during cath procedure |

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**PEDIATRIC**

| Consults/Notifications | | |
|---|---|---|
| [ ] | Notify Physician-Continuing | T;N, For: O2 sat less than 70%, Who:_____ |
| [ ] | Notify Physician-Continuing | T;N, For: O2 sat less than 80%, Who:_____ |
| [ ] | Notify Physician-Continuing | T;N, For: O2 sat less than 90%, Who:_____ |
| [ ] | Notify Physician-Continuing | T;N, For:_____, Who:_____ |
| [ ] | Notify Physician-Once | T;N, For:_____, Who:_____ |
| [ ] | Notify Resident-Continuing | T;N, For:_____, Who:_____ |
| [ ] | Notify Resident-Once | T;N, For:_____, Who:_____ |
| [ ] | Consult MD Group | T;N, Consult Who:_____,Reason:_____ |
| [ ] | Consult MD | T;N, Consult Who:_____,Reason:_____ |

| Date | Time | Physician's Signature | MD Number |
|---|---|---|---|
| _____ | _____ | _____ | _____ |