(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis
HOSPITALS

PROVIDER ORDERS

Order Set Directions:
- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: _____

Allergies with reaction type:_____

Pre-Electrophysiology Study & Ablation Version 1 3/19/2018

RX: Pre-Ablation

Ep Study & Possible Ablation Scheduled start time: _____

Obtain consent for EPS, Possible Ablation & Cardiac Cath: Access: ☐ **Left** ☐ **Right**

- ☐ EPS with possible Ablation _____
- ☐ EPS with possible Heart Cath
- ☐ EPS with possible Device Implant _____

Nursing Orders

- ☐ Clip both groin(s)
- ☐ Clip _____wrist
- ☐ Clip _____elbow region
- ☑ Nursing to document height and weight.

Diet:

- ☐ Clear liquids starting 6 hours prior and NPO 3 hours prior
- ☐ NPO after midnight

IV Line Insert and/or Maintain

- ☐ Peripheral IV insert/maintain
- ☐ Saline lock with saline flush BID

IV Fluids – Maintenance Specific Fluid

IV Fluid-Maintenance

- ☐ Normal saline at 125 milliliters/hour or _____ milliliters/hour starting on arrival or _____
  - If estimated GRF <60, initiate hydration protocol with therapy chosen below:
- ☐ Normal saline 1 milliliter/kilogram/hour for 12 hours pre-procedure until 12 hours post-procedure
- ☐ _____

MEDICATIONS:

☐ Hold the following medications: Hold time: _____

_____

_____

_____

_____

_____

Initials_____

(place patient label here)

Patient Name: _____

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BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

- ☐ Clopidogrel _____milligram by mouth on arrival or at _____
- ☐ Aspirin 325 milligrams by mouth on morning of procedure
- ☐ Ativan _____milligrams by mouth after signing consent, _____ hours prior to procedure
- ☐ Acetylcysteine 1000 milligrams by mouth twice a day x 2 days, starting 24 hours prior to procedure
- ☐ Give the following AM medications:

_____

_____

_____

_____

_____

Lab, if not done within one week:

☐ CBC/AUTO DIFF	☐ Routine
☐ BASIC METABOLIC PANEL	☐ Routine
☐ PT (PROTIME AND INR)	☐ Routine
☐ PTT	☐ Routine
☐ MAGNESIUM LEVEL, PLASMA	☐ Routine

Radiology and Diagnostic Tests:

Pacemaker Evaluation

- ☐ now Reason for exam: _____

☐ EKG (ECG)	☐ Routine
☐ XR Chest PA & Lateral	☐ Routine

Consult Provider

- ☐ Consult Anesthesia

Provider Signature:_____Date:_____Time:_____