(type in hospital specific information here - address, phone, fax)

(Patient ID Information)

# STEMI PHYSICIAN ORDERS - Page 1

**Goal: ED Admit to discharge < 30 MINUTES**

#1. Immediately contact Transporting Emergency Medical Services

Ground:
1st choice: ___________________________
2nd choice: ___________________________

Air: Helicopter
1st choice: _______________________
2nd choice: ______________________

#2. Notify STEMI Receiving Center:

1. Place two (2) peripheral IV's (Heparin lock access: 18 - 20G preferred)
2. Labs: CBC, Electrolytes, BUN, Creatinine, Glucose, Troponin-I, CK-MB, PT/INR/PTT
   Serum HCG if child-bearing age
   *(DO NOT DELAY TRANSPORT FOR LAB RESULTS - Fax lab results to: )*

**(Note: Chart all medication administration on Page 2 STEMI Data Sheet)**

3. Aspirin 325 mg po
4. Platelet Inhibitor ***(in alphbetical order - choose only one)***
   - ☐ Clopidogrel (Plavix) 600 mg PO
   - ☐ Prasugrel (Effient) 60 mg PO
   - ☐ Ticagrelor (Brilinta) 180mg PO
5. Unfractionated Heparin 60 units/kg = _________ units. (maximum 4000 units) IVP
6. Nitroglycerin 0.4mg SL every 5 minutes x 3, PRN for CP unless contraindicated
7. Morphine sulfate 2-4 mg IVP PRN for CP

_______/_______/_______ ______________
Date Time

_________________________
Physician Last Name (print)

________________________________________
Emergency Department Physician Signature

(Patient ID Information)

(type in hospital specific information here - address, phone, fax)

(patient ID information)

# STEMI Patient Data Sheet
# Page 2

AGE: ______ Wt: _________ lbs / kg Ht: __________

| | Allergies | Reaction |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

**IV Contrast:** Y or N **LATEX:** Y or N

| Arrival: (circle one) | Ambulatory | EMS |
|---|---|---|
| | Date | Time |
| Onset of symptoms | | |
| ED Arrival time: | | |
| 1st EKG Time: | | |
| ED Discharge | | |
| Cath Lab Admit: | | |
| Cath Lab Balloon | | |

## MEDICATIONS TAKEN AT HOME

| Medication | Dose | Frequency |
|---|---|---|
| 1. ______________________________ | __________ | _________ |
| 2. ______________________________ | __________ | _________ |
| 3. ______________________________ | __________ | _________ |
| 4. ______________________________ | __________ | _________ |
| 5. ______________________________ | __________ | _________ |

Renal insufficiency Y or N
Last Cr: _______ Date: __________ or unknown
Diabetes: type: _________ Y or N
History of Stroke date: ___________ Y or N
History of bleeding w/transfusion Y or N
Surgery within last six weeks Y or N
History of CABG Date: ____________ Y or N
Surgery within last six weeks Y or N

| Time: | Pulse | Blood Pressure | Respirations |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Notes:

________________________________________________________________________________________________

| Medications | Time | Dose | Route | Signature |
|---|---|---|---|---|
| Aspirin | | | | |
| Heparin | | | | |
| Platelet Inhibitor: **(**___________________**)** | | | | |
| **PRN Medications** | | | | |
| NTG | | | | |
| Morphine | | | | |
| IV fluid: | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

PREP:
All clothes removed: Y or N
Valuables to family Y or N
Bilateral groin hair clipped Y or N
Distal pulses marked Y or N
Family instruction packet Y or N

(Patient ID Information)

| (type in hospital specific information here - address, phone, fax) | (patient information) |
|---|---|

# Thrombolytic Orders - Page 3 (ED admit to CCL admit anticipated > 60 min)

***Checklist MUST BE COMPLETED prior to administion of Fibrinolytic Therapy***

| ***Relative contraindications to Fibrinolytic Therapy:*** | | | ***Absolute contraindications to Fibrinolytic Therapy*** | | |
|---|---|---|---|---|---|
| Active internal bleeding in past 2-4 weeks | Yes | No | Active internal bleeding or bleeding diathesis | Yes | No |
| Acute pericarditis | Yes | No | Any prior Intracranial Hemorrhage | Yes | No |
| Acute subacute bacterial endocarditis | Yes | No | Allergy to thrombolytics | Yes | No |
| Advanced Age > 70 years | Yes | No | Prior exposure to thrombolytics (< 5 days) | Yes | No |
| Bleeding Risk - Diabetic Retinophathy | Yes | No | Ischemic stroke < 3 months | Yes | No |
| CPR > 10 minutes | Yes | No | (exception: acute ischemic stroke within 3 hours) | | |
| Current use of anticoagulants | Yes | No | Known malignant intracranial neoplasm | Yes | No |
| History of prior ischemic stroke > 3 monhts | Yes | No | Known or suspected aortic dissection, | Yes | No |
| Major surgery or trauma within 3 weeks | Yes | No | aneurysm or AVM | | |
| Pregnancy or early postpartum | Yes | No | Intracranial or intraspinal surgery $\leq$ 3 months | Yes | No |
| Corrected Hypertension | Yes | No | Severe uncorrected hypertension | Yes | No |
| (SBP$\geq$ 180 mmHg or DBP $\geq$ 110 mmHG) | | | (SBP$\geq$ 180 mmHg or DBP $\geq$ 110 mmHG) | | |
| Recent GI bleed or active Ulcer disease | Yes | No | | | |
| Severe hepatic and renal dysfunction | Yes | No | | | |

If all answers are "NO" (relative and absolute) proceed with Fibrinolytic therapy - otherwise, consult SRC cardiologist

Thrombolytic **"NOT"** given: (reason): ____________________________________________________________

***Administer only "ONE" medication - (document administration on STEMI Data Sheet - Page 2)***

Fibrinolytic should be given in a dedicated IV line - flush line before and after administration of medication.

☐ Reteplase (Retavase) 10 Units IV over 2 minutes x 2 at 30-minute intervals

☐ Tenecteplase (TNKase) IV over 5 seconds

| Patient Weight | | TNKase | Reconstituted |
|---|---|---|---|
| Kg | Lbs. | (mg) | Volume |
| < 60 | < 132 | 30 | 6 |
| 60 to < 70 | 132 < 154 | 35 | 7 |
| 70 to < 80 | 154 to < 176 | 40 | 8 |
| 80 < 90 | 176 < 198 | 45 | 9 |
| $\geq$ 90 | $\geq$ 198 | 50 | 10 |

☐ Obtain EKG 30 minutes after fibrinolytic administration

______/_______/_________ Time: _________________
Date:

____________________________ ____________________________
Physician Last Name (Print) Physician Signature

Patient ID Information