

- Directions:**
1. Mark through the item you do not wish to order
  2. Indicate choice when options are available by placing a check (✓) in the parenthesis
  3. This order set is intended for patients who develop MI as a secondary diagnosis after admission for another reason – Use CHH 1197 order set for all primary MI admissions

<b>STAT ORDERS for ACUTE CORONARY SYNDROME / ACUTE M.I.</b>	
<input type="checkbox"/> Aspirin – 81 mg chewable tabs x 4; <b>Time given:</b> _____ or <input type="checkbox"/> Reason for not ordering ASA: _____	
<input type="checkbox"/> Cardiac Isoenzymes (CK-MB, Troponin and Myoglobin); <b>Time drawn:</b> _____	
<input type="checkbox"/> STAT EKG: "Chest Pain"	
<b>CONSULT CARDIOLOGIST:</b> _____	
<b>Physician's Signature:</b> _____	<b>Date/Time:</b> _____
<b>Nurse's Signature:</b> _____	<b>Date/Time:</b> _____
1. <input type="checkbox"/> <b>TRANSFER for Critical Cardiac Care</b> preferably on <input type="checkbox"/> CCU or other Critical Care Unit if CCU bed unavailable	
2. <b>MONITORING:</b> Vital signs per unit protocol or <input type="checkbox"/> every ____ hours <input type="checkbox"/> Strict Intake and Output every shift	
<input type="checkbox"/> Weight on arrival to Unit and daily at same time using same scales	
3. <b>ACTIVITY:</b> <input type="checkbox"/> As tolerated <input type="checkbox"/> Bedrest with bathroom privileges <input type="checkbox"/> Bedrest	
4. <b>REHABILITATION:</b> Consult Cardiac Rehabilitation for inpatient and outpatient Cardiac Rehabilitation	
5. <b>DIET:</b> <input type="checkbox"/> Three-gram sodium low animal fat <input type="checkbox"/> Other diet _____ <input type="checkbox"/> Fluid restriction 2000ml/day	
Consult Dietician for Dietary Counseling and instruction in home diet	
<input type="checkbox"/> Saline lock I.V. or <input type="checkbox"/> I.V. Fluids _____ at _____ ml per hour.	
6. <b>EDUCATION:</b> Provide and document <b>Smoking Cessation Counseling</b> for any patient who has smoked within 12 mos.	
7. <b>RECORDS:</b> Copy previous ECHO, Stress or Cardiac Catheterization report within 12 mos. and place on chart	
8. <b>LABS:</b> <input type="checkbox"/> CMP <input type="checkbox"/> Cardiac Enzymes at 0 hour (CK-MB, Troponin and Myoglobin) if not drawn STAT above	
Cardiac Enzymes (CK-MB, Troponin) at 6 hours and 12 hours	
<input type="checkbox"/> Magnesium level <input type="checkbox"/> PT/PTT <input type="checkbox"/> Fasting lipid profile in AM	
<input type="checkbox"/> CBC – Notify Physician if platelets less than 100,000 <input type="checkbox"/> CBC q 2 days while on heparin or enoxaparin (Lovenox)	
9. <b>DIAGNOSTICS:</b> <input type="checkbox"/> EKG in A.M. for next 2 days "Chest Pain – suspected MI"	
10. <b>MEDICATIONS: Notify physician of chest pain requiring PRN medication or significant arrhythmia.</b>	
<b>Arrhythmia treatment per ACLS protocol pending specific orders.</b>	
<input type="checkbox"/> If not given above, <b>Aspirin</b> – 81 mg chewable tabs x 4 STAT, then Aspirin 81 mg orally daily	
<input type="checkbox"/> <b>Nitroglycerin</b> 0.4 mg S.L. chest pain for coronary vasodilatation, may repeat every 5 minutes up to 3x for pain.	
Do not administer <b>Nitroglycerin</b> if SBP 100 or less or signs of cardiogenic shock. Check BP after each dose.	
If chest pain persists, or SBP less than 100, <b>Morphine Sulfate</b> may be used as below. Notify physician if given.	
<input type="checkbox"/> <b>Morphine Sulfate</b> 2 mg I.V. push prn chest pain unrelieved by <b>Nitroglycerin</b> . May repeat up to every 5 minutes	
not to exceed 15 mg. Record vital signs before and after each dose. Notify physician if given.	
<b>THERAPEUTIC ANTICOAGULATION: If estimated GFR less than 30 ml/min, Heparin is a safer alternative.</b>	
<input type="checkbox"/> <b>Heparin (unfractionated)</b> 60 units/kg IV bolus not to exceed 5000 units, followed by infusion of 12 units/kg	
not to exceed 1000 units per hour initially. Call physician with PTT results drawn at 4 hours.	
<input type="checkbox"/> <b>Enoxaparin Sodium (Lovenox)</b> 30 mg IV bolus, THEN 1 mg/kg subcutaneously every 12 hours not to	
exceed 150 mg per dose.	
<b>BETA BLOCKER</b> for cardioprotection: Administer ordered Beta Blocker unless HR less than 60 or SBP less than 100	
Notify physician if Beta Blocker held and document reason.	
<input type="checkbox"/> <b>Metoprolol</b> 5 mg IV over 2 minutes repeated every 5 minutes for a total initial dose of 15 mg, <b>THEN,</b>	
<b>Metoprolol</b> <input type="checkbox"/> 25 mg po every 8 hours OR _____ mg po every 8 hours	
<input type="checkbox"/> <b>Other Beta Blocker:</b> _____	
Or Reason for not ordering Beta Blocker: _____	
<b>ANTI-PLATELET</b> <input type="checkbox"/> Initial dose of <b>Clopidogrel (Plavix)</b> 300 mg (75 mg tabs x 4) po, THEN 75 mg po daily	
<b>STATIN</b> for risk reduction: <input type="checkbox"/> Atorvastatin (Lipitor) 80 mg po daily <input type="checkbox"/> Other Statin _____	

Verbal Order Verification

**Physician's Signature:** \_\_\_\_\_  
**Date/Time:** \_\_\_\_\_

**Patient Identification**