Wentworth-Douglass Hospital
THE SEACOAST'S LEADING MEDICAL CENTER

Cardiovascular Services
789 Central Avenue Dover, NH 03820
Phone: 603−516−4265

Procedure Information

You are schedule for _____**Date:**_____ **with Dr.** _____

Please arrive to the Cardiology department at this Time: _____

Preparing for your procedure

- Nothing to eat eight hours prior to the procedure.
- Clear liquids are ok until 2 hours before the procedure. (i.e. water, apple juice, tea)
- Have transportation arranged to drive you to the hospital and back home.
- Depending on the procedure you may stay overnight.
- Glasses/contacts; hearing aids and dentures can be worn during the procedure.
- You may need to stay in bed for 4−6 hours following the procedure.
- If your procedure is a Pacemaker or ICD insertion, you will stay overnight and be on bed rest
- If you take blood thinners, discuss with your physician when or if you should stop taking them prior to your procedure

MEDICATIONS (the morning of the procedure)

- **DO NOT TAKE**
  - your fluid (diuretic) medication
  - your blood sugar (diabetic) medication whether oral or insulin. (Diabetics please check your blood sugar before coming to the hospital.)
- **PLEASE TAKE** all other medications as prescribed unless you are told otherwise below:

_____
_____
_____
_____
_____

Arriving to the Hospital

Please have the following information ready:

1. List of all your medications prescription and non−prescription including dosages and how many times a day you take them.
2. List of all your allergies
3. Current insurance card

Check in:

The Cardiovascular Department front desk is located on the **3rd** floor of the hospital directly in front of Elevators 1 and 2. Once you are checked in, you will be brought into the Holding area where the Cath lab staff will prepare you for the procedure. The Doctor will start your procedure 30 minutes to 1 hour after you arrive.

If you have any questions please call the office at 603−516−4265

❑ **FRISBIE MEMORIAL HOSPITAL** ❑ **PORTSMOUTH REGIONAL HOSPITAL**
❑ **WENTWORTH−DOUGLASS HOSPITAL** ❑ **WENTWORTH SURGERY CENTER**
❑ **WENTWORTH HEALTH PARTNERS (WHP use only)** _____
Patient Name **DOB**

REASON FOR PROCEDURE: _____

_____

PLANNED PROCEDURE/TREATMENT: _____

_____

PROCEDURE PERFORMED BY DR. (s): _____
and/or his/her associate(s) and any assistants she/he designates.

RISKS: _____

The following are applicable unless marked otherwise below.

I request the administration of blood or blood products if necessary in the judgment of the anesthesiologist or physician performing the procedure or other medical professionals responsible for my care prior to or after the procedure. I understand the potential need for a blood transfusion and available alternatives. I understand that the transfusion of blood is associated with risks that cannot be completely avoided, even by the most careful modern blood banking techniques. These risks include, but are not limited to transmission of infectious disease, particularly hepatitis and acquired immune deficiency syndrome, and the possibility of severe transfusion reactions. These reactions may produce fever, hives, or more serious reactions such as shock and/or kidney shutdown. **N/A _____(initials)**

Portions of my procedure may also be photographed or videotaped for teaching, research or scientific publication, but these photos and videos will not reveal my identity. If any photo or video for teaching, research or scientific publication might reveal my identity, ***I will be asked to sign an authorization for that purpose***. My provider has informed me of any observers that may be present during the procedure and I have been offered the opportunity to object. **N/A _____(initials)**

I understand that portions of the procedure may be photographed or videotaped to document my treatment and that this will be part of my medical record.

I have been informed of the risks, complications, or adverse consequences associated with this procedure including, but not limited to: *infection, bleeding, loss of use of body parts, cardiac arrest, and death.* The above procedure has been fully explained. I have been informed of the benefits of having this procedure and alternative treatments available. I understand that unforeseen complications or conditions may arise during this procedure and I consent to any additional procedures that the physician(s) may deem advisable in their professional judgment. I impose no specific limitations or restrictions on my treatment.

If the administration of local anesthetics, sedatives, and painkillers is deemed necessary in the judgment of the physician performing the procedure, I understand this will produce a general state of sedation during the procedure; and that the potential complications of these medications can include lowering of blood pressure, reduction in breathing and blood oxygen, airway obstruction, and heart rhythm disturbances.

I authorize the physician(s) performing the procedure and the Hospital to preserve any body fluids or tissues removed during the procedure or treatment for scientific or teaching purposes, or to use in the treatment of other patients. I understand that my tissues, fluids or other body parts will not be used for commercial purposes without my written consent. I also authorize the Hospital to dispose of any tissues, body parts or organs removed as a necessary part of my treatment in accordance with acceptable medical practices.

I understand that the practice of medicine is not an exact science and I acknowledge that I have received no guarantees about the benefits or results of treatment. I have read this entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. **All blank spaces have been either completed or lined out prior to my signing this document.** I have been informed that I can change my mind and withdraw consent at any time before the procedure or treatment.

_____	_____	_____
Signature of Patient, Parent, Guardian, Health Care Agent, or Other Representative of Patient	Relationship (if other than patient)	Date / Time

Statement of Practitioner Obtaining Consent:

I certify that I have explained to the patient the risks, benefits, and alternatives of this procedure as well as the probable consequences of receiving no treatment. I have answered all of his/her questions.

_____
Signature of Practitioner

REQUEST FOR PROCEDURE/SURGERY

Hospitalize as: ❑ Inpatient ❑ Outpatient/Observation Care of Dr. _____

All "prechecked" orders will automatically be enacted unless a specific order is written to the contrary. Any additional orders must be "checked" to activate.

Please "check" to activate a specific procedure:

❒ **Cardioversion**

- ☑ Cardioversion, Elective
- ☑ EKG Pre−procedure
- ☑ EKG Post−procedure

−− OR −−

❒ **Cardioversion WITH TEE**

- ☑ Cardioversion, Elective
- ☑ EKG Pre−procedure
- ☑ EKG Post−procedure
- ☑ TEE with Cardioversion

−− OR −−

❒ **TEE**

- ☑ Transesophageal Echo

❒ **Patient Care Orders**

- ☑ NPO (except meds with sips of water) starting at 8 hours prior to procedure. Continue PO medications as ordered.
- ☑ Insert IV #20 gauge with 0.9% Sodium Chloride IV at 30 ml/hour (keep open rate). Avoid hand/wrist for IV access if possible.
- ☑ Communication: Notify provider of most recent INR if patient on warfarin.
- ☑ Communication: Resume diet post−procedure when awake

❒ **Laboratory**

- ❑ Basic Metabolic Panel
- ❑ PT/INR (Anticoag Therapy)
- ❑ CBC with Platelet NO Differential
- ❑ Magnesium

❒ **Medications (for Cardioversion Only)**

- ❑ Silver Sulfadiazine 1% topical cream (Thermazene/ Silvadene) to chest BID PRN skin irritation

☑ **Saline Lock/Saline Flushes**

- ☑ Saline lock administer anesthetic per Policy PC−27
- ☑ Sodium Chloride 0.9% flush syringe (N/S) 10 ml IV PRN
- ☑ Sodium Chlorider 0.9% flush syringe (N/S) 10 ml IV q12H

_____ _____

PHYSICIAN SIGNATURE DATE / TIME