Lucile Salter Packard
Children's Hospital at Stanford
725 WELCH ROAD • PALO ALTO • CA 94304

HISTORY PROGRESS RECORD

PEDIATRIC ELECTROPHYSIOLOGY ADMITTING NOTE

Date: Time:

Referring physician:

Pre-procedure diagnosis:

Procedure planned: ❑ Electrophysiology Study ❑ Radiofrequency Ablation

❑ Pacemaker implantation ❑ ICD implantation

❑ Other:

Pertinent medical history

Indication for procedure:

Body system involved

Current medications / last dose: Allergies:

Physical Examination: **BP:**_____ **HR:** _____ **RR:**_____ **Weight:** _____

Neuro: ❑ Alert ❑ Oriented x3 ❑ Cranial nerves intact ❑ Motor exam non-focal ❑ Sensation intact
Other findings:

Cardiac: ❑ Regular rate and rhythm ❑ No murmurs/rubs/gallops ❑ No jugular venous distention (JVD)
Other findings:

Lungs: ❑ Clear to ausculation ❑ Clear percussion ❑ Normal symmetry and expansion
Other findings:

Neck/Back: ❑ Supple ❑ No thyromegaly ❑ No costovertebral angle tenderness
Other findings:

Abdomen: ❑ Soft ❑ Non-tender ❑ Normal bowel sounds ❑ No organomegaly ❑ No masses palpable
Other findings:

Extremities: ❑ No cyanosis ❑ No clubbing ❑ No edema Pulses +2 Other findings:

ECG, Echo, Laboratory data:

❑ The benefits, alternatives to, and most likely risks of the procedure were discussed with the patient / patient's parent / guardian, and they have consented to the procedure. (initial _____)

SPECIFIC RISKS DISCUSSED: Risks include, but are not limited, to: ❑ bleeding ❑ infection ❑ hematoma ❑ arrhythmia ❑ AV block ❑ perforation ❑ stroke ❑ death ❑ risks of conscious and deep sedation

Others:

Plan for post-procedure care: ❑ PICU ❑ PACU ❑ 3-North

Signed: _____MD Beeper # _____Examining Physician

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

CONSENT TO OPERATION, PROCEDURE AND ADMINISTRATION OF ANESTHESIA

Dear Patient,

The purpose of this form is to advise you of important information regarding your operation or procedure recommended by your practitioner. **PLEASE READ THE ENTIRE FORM CAREFULLY BEFORE SIGNING.**

You have the right to be informed of the nature of your operation or procedure, and its risks, benefits and alternatives. Except in an emergency, an operation or procedure is not performed until you have had the opportunity to receive this information and have given your consent. Any operation or procedure may involve the risk of an unsuccessful result or complication, including but not limited to bleeding, infection, nerve/nervous system damage, injury or even death from both known and unforeseen causes. You have the right to consent to or refuse any proposed operation or procedure at any time prior to its performance. Your other medical care will not be adversely affected if you decide to withhold or withdraw your consent to this proposed treatment.

In addition to caring for patients, Stanford Hospital and Clinics (SHC) and Lucile Packard Children's Hospital (LPCH) are educational institutions. As part of the medical education program, residents, interns, medical students, postgraduate fellows, and other health care students may, under supervision of your attending physician, participate in your care.

Your signature on this form authorizes the pathologist to use his or her discretion in disposition of any member, organ or tissue removed from you during this operation or procedure.

The following operation or procedure will be carried out by the practitioner obtaining this consent together with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff.

NAME OF PRACTITIONER performing procedure: _____

OPERATION OR PROCEDURE (Spell out all words, do not abbreviate): _____

Electrophysiology study and Radiofrequency Ablation

Additional comments by practitioner (if any):

PATIENT: By my signature below, I confirm that:

1. I have read and understand the information provided on this form, and the operation or procedure and its risks have been explained to me.
2. I have had the opportunity to ask questions and have received all the information I desire about the operation or procedure.
3. I understand that in an emergency there may be different or further procedures required if my doctor believes they are necessary, and I consent to such procedures.
4. I authorize the administration of anesthesia/sedation and associated procedures performed as part of anesthesia administration if it is determined to be necessary to assure my safety and comfort, and understand that certain risks and complications may be associated with the use of anesthesia and/or sedation and the associated procedures.
5. I consent to the taking and transmittal of photographic and electronic reproductions that are necessary as an intrinsic part of my operation or procedure, and to the use of the same for SHC/LPCH internal training activities and quality assurance review. To the extent that I am not identifiable from such photographic or electronic reproductions, they may be used for scientific or educational purposes.
6. I consent to the performance of the operation or procedure listed above.

_____ DATE _____ TIME _____ SIGNATURE (Patient, Parent or Properly Designated Representative)

_____ RELATIONSHIP to Patient

If this document was translated: _____ SIGNATURE (Interpreter) _____ Date _____ Time _____ Language

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Implantation of transvenous pacemaker

Additional comments by practitioner (if any):

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NAME OF PRACTITIONER performing procedure: _____

OPERATION OR PROCEDURE (Spell out all words, do not abbreviate): _____

Implantation of transvenous implantable cardioverter-defibrillator (ICD)

Additional comments by practitioner (if any):

PATIENT: By my signature below, I confirm that:

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CONSENT TO OPERATION, PROCEDURE AND ADMINISTRATION OF ANESTHESIA

INFORMED CONSENT ATTESTATION:

I have explained to the patient the nature of his/her condition, the nature of the operation or procedure and the benefits to be reasonably expected compared with alternative approaches.

I have discussed the likelihood of major risks or complications associated with this operation or procedure. I have also indicated that with any procedure there is always the possibility of an unexpected complication, and no guarantees or promises can be made concerning the results of any procedure or treatment.

❑ Yes ❑ No Moderate (conscious) sedation is planned to be used or may potentially be used during this procedure.

If yes, I have discussed the use of moderate sedation, also known as conscious sedation. These medications are administered to help the patient relax and relieve discomfort during the procedure. The risks include slower breathing, low blood pressure and occasionally, incomplete pain relief.

If no, and anesthesia is to be administered, the anesthesiologist will discuss the risks, benefits and alternatives of anesthesia with the patient and document.

❑ Yes ❑ No Blood or blood product transfusion is planned to be used and/or may potentially be used during this operation or procedure.

If yes, I have discussed the risks, benefits and alternatives of transfusion and provided the patient or his/her representative with the pamphlet "A Patient's Guide to Blood Transfusions" as required by the state of California (Gann Act).

All questions were answered and the patient consents to the procedure.

DATE _____ TIME _____

SIGNATURE and TITLE of Practitioner _____ Print Name _____ Dictation Number _____

Note to Practitioner:

If use of a photographic or electronic reproduction does not fall specifically within the parameters of number 5 on the previous page, please be aware of the following additional requirements that may apply:

1. The patient's consent using the "Consent to Photograph" form (15-213 or 5775) must be obtained if any photographic or electronic reproductions that are ***not intrinsic to the operation or procedure*** are taken or transmitted for any reason.
2. The patient's authorization must be obtained if photographic or electronic reproductions ***that identify the patient*** are used or transmitted for any purpose other than the patient's treatment, or SHC/LPCH's internal training activities or quality assurance review. For more information, please consult with the SHC/LPCH Privacy Office.
3. Special rules apply to use of photographic or electronic reproductions for research purposes. For more information, please consult with the appropriate Stanford Institutional Review Board (IRB) or access the IRB website at http:\\humansubjects.stanford.edu.

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PEDIATRIC ELECTROPHYSIOLOGY STUDY PRE-PROCEDURE ORDERS

Date/Time	
	1. Admit to ❑ PACU ❑ _____
	2. Diagnosis:
	2: Procedure: ❑ Electrophysiology Study ❑ Radiofrequency Ablation
	❑ Cardioversion ❑ Pacemaker implant:
	❑ ICD implant ❑ Tilt Table Test:
	❑ Other: _____
	3: Condition: Wt. _____ kg
	4 Allergies:
	5 Attending: ❑ Van Hare (#13916) ❑ Dubin (#13906) ❑ Collins (#415-607-2542)
	❑ Other: _____
	6. ❑ Vital signs, including height and weight, on arrival
	7. EMLA cream to ❑ both groins ❑ _____ neck ❑ IV start site
	❑ Please shave both groins prior to EMLA cream
	8. ❑ Start IV and heplock flush as per routine
	10 Labs to be drawn/sent in PACU:
	❑ Hgb/Hct ❑ Hold clot tube
	❑ Type and Hold ❑ Type and cross, _____ units
	11 ❑ Female patients 12 years and older: Urine beta HCG
	12: Please insure patient has witnessed consent form in chart
	13: Transfer to Cardiac Catheterization Laboratory
	14: Other orders:
	Signed: _____, MD Pager # _____

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PEDIATRIC ELECTROPHYSIOLOGY STUDY POST-PROCEDURE ORDERS (page 1)

Date/Time	1. Diagnosis:
	2: Procedure: ❑ Electrophysiology Study ❑ Radiofrequency Ablation ❑ Cardioversion ❑ Pacemaker implant: ❑ ICD implant ❑ Tilt Table Test: ❑ Other: _____
	3: Condition: Wt. _____ kg
	4. Complications:
	5: Allergies
	6: Access: ❑ RFV ❑ LFV ❑ RFA ❑ LFA ❑ RIJV ❑ RSCV ❑ LSCV ❑ Rt chest ❑ Lt chest : ❑ Other: _____
	7. ❑ Continuous telemetry. Low HR limit: _____ High HR limit: _____
	8. ❑ Vital signs: check temperature, heart rate, respirations, blood pressure, catheterization/device implant sites, and perfusion:
	Every 15 minutes for 1 hour
	Every 30 minutes for 2nd hour
	Every 60 minutes for next 4 hours
	Then once every 4 hours
	9. ❑ Bed rest with effects leg(s) straight for 4 hours after venous puncture
	❑ Bed rest with effects leg(s) straight for 6 hours after arterial puncture
	❑ Head elevated 30 degrees for 4 hours after jugular or subclavian puncture
	10 ❑ NPO until fully awake, then advance diet as tolerated
	11 ❑ IV to heparin lock with flushes as per routine
	12. ❑ IV fluid: D5 1/4 NS at _____ cc/hour until taking PO well.
	13. ❑ STAT portable chest X-Ray, AP view, to rule out pneumothorax
	Signed: _____,MD. Pager # _____
	(go to next page please)

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PEDIATRIC ELECTROPHYSIOLOGY STUDY POST-PROCEDURE ORDERS (page 2)

Date/Time	
	14. ❑ Notify Cardiology Fellow for abnormal vital signs, arrhythmias, bleeding. Pager #:___________________
	❑ Notify Cardiology Attending for abnormal vital signs, arrhythmias, bleeding. Pager #:___________________
	15. Medications:
	❑ Zofran __________________ mg IV every x 1 PRN nausea/emesis (0.15 mg/kg, 4 mg max) ❑ Ketorolac _______________mg IV every 6 hours for pain (0.5 mg/kg, 30 mg max) ❑ Kefzol _________________mg IV every 8 hours (25 mg/kg, 500mg max) ❑ Acetaminophen ___________mg PO every 4 hours PRN pain (10 mg/kg, 650 max) ❑ Morphine ________________mg IV every 1-2 hours PRN pain
	16. ❑ Other medications:
	17. ❑ May discharge home at ___________________________ if stable without bleeding, vomiting, arrhythmias, excessive pain, or other problems. Please notify cardiology attending or fellow at time of discharge.
	18. ❑ Other orders:
	Signed: _______________________________________, MD. Pager # ______________________