Template AMI Orders

This standard order template is based on the ACC/AHA Guidelines for the Management of Patients With Acute Myocardial Infarction and is intended to capture key elements of care for an AMI patient as recommended in the guideline. It is not intended to be as exhaustive and detailed as it would need to be in order to be used in practice. It is not intended to be used "as is" but is intended to be modified for implementation at your institution. It is expected that you will need to add a considerable amount of detail in order to make this template into a fully functional standard order.

Items presented in **bold text** in this standard order template are considered by the ACC to be elements of an AMI standard order because they are based on Class I recommendations from the ACC/AHA AMI Guidelines. Removal of any of these items would result in a standard order that does not reflect the ACC/AHA recommended care for an AMI patient. This PDF contains embedded links. Clicking on terms in **bold text** will open your default web browser to the Class I recommendation in the AMI Guidelines.

☐ Admit to CCU ☐ Admit to Cardiac Stepdown Unit ☐ AMI Pathway

Diagnosis: ☐ ST Elevation or True Posterior ( ↑ R, STD, ↑ T $V_1 – V_3$) AMI ☐ Non-STEMI, T ↓ AMI

Attending Physician: _____ Cardiologist: _____

☐ Obtain old chart

☐ VS per unit protocol; I & O's; daily weights

☐ Pulse oximeter on admission, every _____ hrs, then p.r.n.

☐ Nasal $O_2$ at 2–4 L/min; maintain $SaO_2$ >90%

☐ If $SaO_2$ < 90%, Ventimask at _____%

Establish ☐ 1 ☐ 2 IV lines _____at____ ☐ kvo ☐ _____at_____cc/hr

Activity: ☐ Complete bed rest ☐ Bed rest with bedside commode ☐ Bed rest with BR privileges

☐ Progress as tolerated

Diet: ☐ Low saturated fat/ low cholesterol ☐ ADA ____ calories ☐ NAS

☐ 2 gm Na ☐ clear liquids ☐ NPO

MEDICATIONS

☐ **Aspirin** _____ mg (160-325 mg) to be chewed now. ☐ aspirin contraindicated because: _____

☐ **Enteric Coated Aspirin Daily** ☐ 325 mg ☐ 162 mg ☐ 81 mg ☐ aspirin contraindicated because: _____

☐ clopidogrel 75 mg p.o. daily (for ASA allergy) loading dose of 300–375 mg for first dose prior to PCI

☐ ticlopidine 500 mg loading plus 250 mg twice daily

☐ **IV Nitroglycerin** bolus injection of 12.5–25 mcg and a pump-controlled infusion of 10–20 mcg/min, and increase the dosage by 5–10 mcg every 5–10 minutes titrate per protocol.

☐ nitropaste _____ inch twice daily ☐ isordil

☐ Heparin

☐ For pts <70 kg, 60 units/kg bolus (maximum 4000 units), then 12 units/kg/hr (maximum infusion 1000 units/hr) – then as per nomogram (target aPTT 50–70 seconds) for 48 hrs

OR

☐ For pts >70 kg, 4000 units bolus, then 1000 units/hr–then as per nomogram (target aPTT 50–70 seconds) for 48 hrs

☐ subcutaneous heparin 7500 units twice daily until ambulatory

☐ Low Molecular Weight Heparin

☐ enoxaparin 1 mg/kg subcutaneous every 12 hrs (alternate antithrombotic for non–STEMI)

☐ dalteparin 120 units/kg of body weight, max 10,000 units subcutaneous every 12 hrs

☐ IV GPIIb/IIIa

☐ abciximab 0.25 mg/kg IV bolus; then continuous IV infusion of 0.125 mcg/kg/min (max 10 mcg/min) for 12 to 24 hrs

☐ eptifibatide 180 mcg/kg IV bolus over 1–2 min; then 2.0 mcg/kg/min for 72 to 96 hrs

☐ tirofiban 0.4 mcg/kg/min over 30 min; then 0.1 mcg/kg/min for 48 to 96 hrs

☐ **Beta Blocker**

☐ metoprolol 5 mg IV over 2 min repeated every 5 min for a total initial dose of 15 mg

☐ atenolol 5 mg IV repeated 5 min later

☐ _____

☐ Beta Blocker contraindicated because: _____

☐ Morphine Sulfate 2–4 mg IV p.r.n. for chest pain if unrelieved by conventional therapy

☐ Hospital **Thrombolytic Protocol**–administer within 30 min upon arrival of patient in ED

☐ alteplase 15 mg IV bolus; 0.75 mg/kg (max 50 mg) over 30 min; 0.5 mg/kg (max 35 mg) over 60 min

☐ reteplase double bolus 10 units each 30 min apart

☐ streptokinase 1.5 million units in 30–60 min

☐ tenecteplase 30 mg for pts < 60 kg; 35 mg for pts 60 to <70 kg; 40 mg for pts 70 to <80 kg; 45 mg for pts 80 to <90 kg; 50 mg for pts = or > 90 kg

☐ Thrombolytic contraindicated because: _____

☐ Proceed immediately to Cath Lab for primary PCI–assure door to dilation time within 90 (± 30) min

☐ **ACE-Inhibitor**

☐ lisinopril 5 mg p.o. daily titrate upward p.r.n. for BP

☐ captopril 6.25 mg p.o., then 12.5 mg 2 hrs later and 25 mg three times daily

☐ enalapril 2.5 mg twice daily

☐ ramipril 5–10 mg every day

☐ _____

☐ ACE-inhibitor contraindicated because: _____

☐ **Cholesterol-lowering drug**

☐ niacin

☐ gemfibrozil

☐ statin (preferred for isolated increase in LDL): _____, _____mg/p.o. with evening meal

☐ Diuretic: _____, _____mg ☐ p.o. ☐ IV _____

☐ Compazine 5–10 mg IV every 4 hrs p.r.n. for nausea/vomiting

☐ Stool softeners 100 mg p.o. twice daily

☐ Antacids 30 cc p.m. daily

☐ Acetaminophen 2 tabs every 4–6 hrs p.r.n.

STUDIES: (If not done in ED)

☐ CBC with diff ☐ repeat in a.m.

☐ BUN, creatinine, Lytes ☐ repeat in a.m.

☐ Mg, Ca, Phos

☐ Glucose

☐ PT, INR, aPTT

☐ Cardiac markers: ☐ troponin-T, troponin-I ☐ CK, CK-MB–as per hospital protocol

☐ Lipid profile now (if not performed in past 4 months)

☐ Fasting lipid profile in a.m.

☐ ECG upon arrival to Unit and in a.m. ☐ Right-sided ECG

☐ ECG with recurrent chest pain

☐ Portable chest x-ray

☐ _____

☐ _____

☐ _____

INTERVENTIONS

☐ Patient Education Form/Program

☐ Smoking cessation instruction and counseling program- for all patients who smoke

☐ Nutritional counseling

☐ Secondary prevention counseling

☐ Discharge contract re: understanding and complying with evidence-based therapy

☐ Cardiac Rehabilitation

☐ Notify MD immediately for Recurrent symptoms/ECG ischemia/CHF/Hemodynamic decompensation/Ventricular arrhythmias

☐ Cardiac catherization: Primary PCI, Rescue for the failed thrombolysis, clinical conditions, cardiogenic shock/hemodynamic instability/CHF, suspected mechanical complications, eg. VSD, acute MR, malignant ventricular arrhythmia, ischemia in-hospital or pre-discharge ETT, recurrent ischemia at rest with ECG changes (or repeated episodes without ECG changes), recurrent MI, high-risk non-STEMI patient