BRONCH/EBUS/SUPER-D COVER SHEET

PATIENT NAME: _____

PRE-OP DATE/TIME: _____

BRONCH DATE/TIME: _____

ORDERS: _____

H AND P: _____

CXR: _____

LABS: _____

CONSENT FORM: _____

CALL PATHOLOGY: _____
(904)819-3716

CALL CHRISTINA (SUPER-D): _____
(904)460-6948

STAFF PREPARING: _____ DATE: _____

STAFF RECEIVING: _____ DATE: _____

FAX COMPLETED PACKET TO (904)819-4901

BRONCH INSTRUCTIONS

PATIENT NAME: _____

***ARRIVE IN OUTPATIENT AT _____AM / PM ON _____,
_____***

NOTHING TO EAT OR DRINK AFTER MIDNIGHT

IF YOU TAKE COUMADIN, PLAVIX, OR ASPIRIN--STOP THIS MEDICINE ON _____ (FOR EBUS OR SUPER-D, 5 DAYS BEFORE)

TAKE YOUR BLOOD PRESSURE MEDICINE AT YOUR NORMAL TIME

DO NOT TAKE ANY DIABETIC MEDICINES PRIOR TO COMING

BE SURE TO HAVE SOMEONE THAT CAN DRIVE YOU HOME OR YOU WILL NOT BE PERMITTED TO LEAVE

Flagler Hospital, Inc., St. Augustine, Florida

DOCTOR'S ORDERS

DATE	TIME	NURSES' SIGNATURE	CK.	ORDERS

PRE & POST BRONCHOSCOPY ORDERS

Check desired boxes.

PRE-BRONCHOSCOPY

1. Procedure to be done on: *(date)* _____ at *(time)* _____
   in: [✓] Endoscopy Suite in OR [ ] Bronch Suite [ ] Bedside *(Inpatient)*
   as an: [✓] Outpatient [ ] Inpatient [ ] Outpatient TBA Post-Bronch [ ] Obs.
2. Anesthesia: [✓] Deep Sedation (MAC) [ ] IV Sedation [ ] LMA
3. NPO after midnight on _____ except for meds with sip of water.
4. Indications for procedure: _____
5. Consent to read: Bronchoscopy with washings, lavage, brushings, biopsies, needle aspiration, laser as needed. Please have consent on chart.
6. Consent for IV Sedation when applicable. Please have consent on chart.
7. Labs: If done within 2 weeks, do not repeat unless results were abnormal.
   - [✓] CBC
   - [ ] BMP *(Basic Metabolic Panel)*
   - [✓] PT/INR
   - [✓] PTT
   - [ ] Platelet Function Test
   - [✓] CXR: [ ] Portable [ ] PA/LAT
   - [ ] EKG
8. Pre-Medication:
   - [ ] Per Anesthesia
   - [ ] _____
   - [ ] _____
   - [ ] _____
9. IV:
   - [ ] NS @ KVO or @ ____ ml hour
   - [ ] INT
10. [ ] Titrate FiO_2 for SpO_2 > 92%.

_____ Physician Signature

POST-BRONCHOSCOPY:

1. Admit Post-Bronch to: [✓] PACU [ ] OPS [ ] Patient's Room
2. NPO for 2 hours after procedure or until awake, alert, and has a positive gag reflex.
3. Bed rest for 2 hours after procedure or until _____.
4. Vital signs every 15 minutes x 4, then every 30 minutes x 4, then routine.
5. [✓] Call Physician if heart rate > 130 and/or SBP < 90.
6. [✓] Call Physician if hemoptysis > 5ml total at any time.
7. [ ] Upright portable expiration CXR to rule out pneumothorax, **now** or at _____ a.m./p.m. **Call MD with results.**
8. Call Physician if patient exhibits dyspnea/stridor.
9. [✓] Respiratory treatment with Albuterol 2.5mg PRN for shortness of breath.

IF OUT-PATIENT PROCEDURE:

- [✓] Call Physician before discharged home.
- [ ] Follow-up appointment: _____
- [ ] Prescription: _____
- [✓] Instructions for patient: Rest at home today. Call MD if in any distress or hemoptysis >5ml total at any time.

Date _____ Physician Signature _____

Flagler Health+

Patient Label

CONSENT FOR OPERATION AND/OR INVASIVE PROCEDURE

Verification of Procedure(s) to be performed (***Must include laterality, if pertinent**):
Bronchoscopy with washings, lavage, brushings, biopsies, needle aspiration, laser as needed.

to be performed by _____ and such assistants as he/she may designate.

Acknowledgement of Informed Consent _____ _____ _____
Provider's signature Date Time

- **I hereby confirm that I have given consent to the above named procedure performed by the healthcare provider(s) named. I acknowledge that my provider has explained proposed care, treatment and services, potential benefits, risks and side effects of the procedure, as well as the likelihood of achieving goals of treatment and any potential problems that might occur during my recuperation.**
- **I acknowledge that my provider has explained to me the reasonable alternatives to proposed care, treatment and services, as well as risks, benefits and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment and services.**
- **I acknowledge that my provider has explained the specific risks of the proposed procedure(s) named and possible complications, including but not limited to the chance of failure of the procedure and the possibility of unplanned injuries to organs, nerves or blood vessels including but not limited to inadvertent puncture, laceration or tearing of other internal organs and consequent bleeding and the need for additional surgery/procedures.**
- **I also acknowledge that I have been informed that there are other risks with the performance of any invasive procedure, including but not limited to severe blood loss, infections, cardiac (heart) failure or cardiac arrest, and others up to and including death.**
- **If my provider determines that a pelvic examination (an internal examination of female reproductive organs performed manually, with the provider's gloved hand or instrumentation) is necessary, or becomes necessary, I consent to same.**
- I recognize that during the course of the procedure, unforeseen conditions may require additional or different procedures than that listed above. I therefore give my consent and authorize my provider(s) and/or his/her assistants to perform such procedures as are, in the exercise of professional medical judgement, necessary and desirable including but not limited to procedures involving additional operations or procedures.
- If this procedure involves childbirth, I authorize the above named provider and such assistants as may be designated by him/her to perform such procedures for and to render treatment to my baby as necessary and desirable in the exercise of professional judgment.
- I understand that surgically removed tissue may be examined and retained by the Hospital for medical/diagnostic purposes. I consent to the disposition of tissue or parts removed during such treatment by the Hospital in accordance with customary practice. I understand that tissue and/or devices or implants removed will not be released by the Hospital without appropriate authorization.
- I understand that a technical support representative/company representative may be requested during my procedure and deemed necessary by my surgeon. I consent to the presence of such support representative(s) for my procedure(s).
- I consent to the possibility of observer(s) or student(s) observing my procedure or surgery.
- I have read or had read to me and fully understand this consent. I have been given the opportunity to ask questions and have my questions answered.

( ) PATIENT IS A MINOR
( ) PATIENT IS UNABLE TO SIGN

Patient's signature: _____

Date: _____ Time: _____ (a.m./p.m.)

Authorizing signature: _____

Relationship to patient: _____

Date: _____ Time: _____ (a.m./p.m.)

Witness/Interpreter signature: _____

Date: _____ Time: _____ (a.m./p.m.)