

Big County Regional Advisory Council
Regional STEMI Plan
STEMI: THROMBOLYTIC CHECKLIST

Photocopy This Form and Leave A Copy With Emergency Department Physician At Bedside

INCIDENT

Date _____ Agency _____ Unit# _____

Patient Name _____ Age _____ DOB _____

INDICATIONS FOR USE OF CHECKLIST

For Patient's experiencing chest discomfort for greater than 15 minutes and less than 12 hours, AND
12-lead ECG shows STEMI or presumable new LBBB.

Are there any contraindications to fibrinolysis?

- | | |
|---|---|
| Systolic BP greater than 180 mm/Hg | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diastolic BP greater than 110 mm/Hg | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Right vs. left arm systolic BP difference greater than 15 mm Hg | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| History of structural central nervous system disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Significant closed head facial trauma within previous 3 months | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Recent (within 6 weeks) major trauma, surgery (including laser eye surgery), GI/GU bleed | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding or clotting problem or on blood thinners | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CPR greater than 10 minutes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pregnant female | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Serious systemic disease (e.g., advanced/terminal cancer, severe liver or kidney disease) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Is patient at high risk?

- | | |
|---|--|
| Heart rate greater than or equal to 100 bpm AND systolic BP less than 100 mm/Hg | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pulmonary edema (rales) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Signs of shock (cool, clammy) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contraindications to fibrinolytic therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Comments

**Big County Regional Advisory Council
Regional STEMI Plan
BCRAC Regional STEMI Alert Form**

Name: _____			Date: _____
DOB: _____	AGE: _____	Symptom Onset Time: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female

EMS to complete this section (Provider Name) _____

<input type="checkbox"/> Patient contact time: _____ <input type="checkbox"/> O ₂ _____ Lpm, via _____ <input type="checkbox"/> Started IV w/ _____ gauge <input type="checkbox"/> 12-lead administered Time: _____ <input type="checkbox"/> 12-lead transmitted or called to facility Time: _____ <input type="checkbox"/> 4 chewable baby aspirin (or equivalent) PO, unless contraindicated Time: _____	<input type="checkbox"/> NTG 0.4 mg SL q 5 minutes x 3, unless contraindicated Time: _____ / _____ / _____ <input type="checkbox"/> Other Treatment: _____ _____ Medic Name (Printed): _____ Signature: _____
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RURAL HOSPITAL to complete this section (Provider Name) _____

<input type="checkbox"/> Hospital: _____ <input type="checkbox"/> Patient arrival time: _____ <input type="checkbox"/> Activate Code STEMI Time: _____ <input type="checkbox"/> STAT EKG & continuous cardiac monitoring. Notify ED Physician: _____ Time: _____ <input type="checkbox"/> O ₂ _____ Lpm, via _____ <input type="checkbox"/> Ensure 2 IV lines <input type="checkbox"/> STAT lab: CBC, CMP, PT/PTT, CK, CKMB, Troponin I <input type="checkbox"/> Chest X-ray completed Time: _____ <input type="checkbox"/> 4 chewable baby aspirin (or equivalent) PO, unless contraindicated Time: _____ <input type="checkbox"/> NTG 0.4 mg SL q 5 minutes x 3, unless contraindicated Time: _____	<input type="checkbox"/> Other Treatment: _____ <input type="checkbox"/> IF STEMI or left bundle branch block, call for acceptance of CODE STEMI Time Called: _____ Time Accept: _____ <input type="checkbox"/> Receiving Hospital: _____ <input type="checkbox"/> If thrombolytics given, please use Heparin - Drug/Dose: _____ Route: _____ Time: _____ <input type="checkbox"/> Contact EMS (ground or air) for priority transfer Provider: _____ Time called: _____ <input type="checkbox"/> EMS arrived Time: _____ Patient leaves ED Time: _____ <input type="checkbox"/> Call Cardiologist when patient has left facility. Nurse Name (Printed): _____ Signature: _____
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TRANSFER EMS to complete this section (Provider Name) _____

Patient arrival time: _____ Notes: _____

STEMI FACILITY to complete this section (Provider Name) _____

<input type="checkbox"/> Patient arrival time: _____ <input type="checkbox"/> Activate Code STEMI Time: _____ <input type="checkbox"/> STAT EKG Time: _____ & continuous cardiac monitoring. Notify Cardiologist: _____ Time called: _____ Time Arrived: _____ <input type="checkbox"/> O ₂ _____ Lpm, via _____ <input type="checkbox"/> Ensure 2 IV lines <input type="checkbox"/> STAT lab: CBC, CMP, PT/PTT, AMIP <input type="checkbox"/> Chest X-ray completed Time: _____ <input type="checkbox"/> 4 chewable baby aspirin (or equivalent) PO, unless contraindicated Time: _____ <input type="checkbox"/> NTG 0.4 mg SL q 5 minutes x 3, unless contraindicated Time: _____ <input type="checkbox"/> Heparin Bolus: Dose _____ Time _____ <input type="checkbox"/> Heparin Drip: Dose _____ Time _____ <input type="checkbox"/> Morphine: Dose _____ Time _____	<input type="checkbox"/> Other Treatment: _____ <input type="checkbox"/> If thrombolytics given - Drug/Dose: _____ Route: _____ Time: _____ <input type="checkbox"/> Prep Patient for Cath: <input type="checkbox"/> Remove all patient's clothes; hospital gown only <input type="checkbox"/> Name/allergy bands on patient <input type="checkbox"/> IV x 2 with extension tubing <input type="checkbox"/> IV: NS at KVO rate for primary line <input type="checkbox"/> Connect patient to the portable monitor <input type="checkbox"/> Portable O ₂ tank on stretcher <input type="checkbox"/> Place consent on chart; ensure patient has signed consent after explanation from cardiologist <input type="checkbox"/> Patient leaves ED for Cath Lab. Time: _____ Nurse Name (Printed): _____ Signature: _____
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CATH LAB to complete this section (Provider Name) _____

<input type="checkbox"/> Patient arrives in Cath Lab: _____ <input type="checkbox"/> Arrival of Interventionalist: _____ <input type="checkbox"/> First Lesion Access: _____ <input type="checkbox"/> Reperfusion time/intervention complete: _____ / _____	<input type="checkbox"/> ICU Notified for Room: _____ <input type="checkbox"/> Patient leaves Cath Lab: _____ Nurse Name (Printed): _____ Signature: _____
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Regional Goal: 90 minutes or less from initial medical contact to balloon inflation.