YOUR HOSPITAL	Emergency Department QualChart®
ORDER SHEET / CARDIAC	Height: _____ Weight: _____ lbs / kgs Allergies: _____

✱ HQI INDICATOR ▲ PQRI INDICATOR

~ TIME ALL ORDERS ~

Time:	LABORATORY: Circle specific orders	By:	Time:
	Cardiac Panel		
	CBC Manual Diff		
	BMP CMP LFT Mg		
	✱ *Lipid Profile / LDL-Cholesterol*		
	Amylase Lipase Ammonia		
	UA UA w/o Micro CC Cath		
	UCG HCG: Qual / Quant		
	Drug Screen: Urine / Serum ETOH		
	CPK CKMB Troponin		
	Cardiac Enzymes q _____ hours x _____		
	D - Dimer BNP Myoglobin		
	ESR Uric Acid		
	PT / INR PTT		
	Digoxin		
	Hemoccult Gastroccult		
	ABG On Room Air		
	Cultures: Urine Sputum		
	✱ *Blood* ✱ *Blood x 2*		

Time:	RADIOLOGY: Circle specific orders	By:	Time:
	CXR (2 view) Portable CXR		
	CT: Chest Contrast: IV PO None		
	CT: Abdomen / Pelvis Contrast: IV PO None		
	CT: Head / Facial Bones Contrast: IV PO None		
	Ultrasound of: GB ABD Pelvis		

Indication(s) for Xray / CT / US: _____

Xray Interp: No Acute Changes Positive _____

By: ED Physician Radiologist _____

SAMPLE

CARDIAC MONITOR / EKG	By:	Time:
Monitor ▲ EKG		
Repeat EKG @_____		
Repeat EKG @_____		
Repeat EKG @_____		
Pull Previous Medical Records, including EKG(s)		

RESPIRATORY THERAPY:	Int/Tm	Int/Tm	Int/Tm
Albuterol Unit Dose or _____ mg x 1 2 3 q _____ min			
q _____ min			
q _____ min			
q _____ min			
Peak Flow: Pre-Tx: _____ Post-Tx #1: _____ Post-Tx #2: _____			

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TREATMENT ORDERS:	By:	Time:
Repeat Vital Signs: All BP Pulse RR Temp O2 Sat		
▲ ✱ *Pulse Ox* O2 @ _____ l/min via NC / Mask / NRB		
Saline Lock IV: NS LR Bolus _____ ml over _____ min/hr		
Maintenance IV: NS LR _____ ml/hr		
Bilateral Upper Extremity Blood Pressures		
▲ ✱ *ASA* 162 / 325 mg PO **N/A:** ASA ↓24 hrs GI Disease Allergy		
✱ *Metoprolol* 25 / _____ mg po 5 / _____ mg IV **N/A:** Pulse ↓ 60 SPB ↓100 mg Hg		
AV Block Asthma Cocaine LV Dysfunction		
Clopidogrel Bisulfate 75 or 300 mg PO		
Nitroglycerin Sublingual 0.4 mg x _____ Nitroglycerin Paste _____ Inches to Chest		
Please Attach Hospital-Specific In-Patient Order Set For: _____		
Disposition Orders: Discharge Admit to InPt Status Observation Transfer		

Critical Care Provided for: 30-74 min / 75-104 min / _____ min

SIGNATURE:

Time of Initial Orders: _____ **a.m. / p.m.**

_____ MD / DO

_____ PA / NP / Resident

_____ RN / Init

_____ RN / Init

* 0 S 1 3 4 0 0 1 0 0 0 0 0 0 1 9 7 1 *

This form is to assist the physician's documentation of clinical care and treatment.
It is not intended to supplant that judgement or create a standard of care.
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