[your logo here]

PRACTITIONER PRE-PRINTED ORDERS
Atrial Fibrillation / Atrial Flutter
Emergency Department

To complete the order form, fill in required blanks and/or check the appropriate boxes.
Bulleted items will be initiated automatically.
To delete orders, draw one line through the item and initial.

Allergies: See Allergy / Intolerance Record	Patient Weight Est._____kg Actual ______kg

Posted Initial	ORDERS AND SIGNATURE
	Diagnosis • Atrial fibrillation / atrial flutter
	Investigations or Tests • 12-lead ECG **OR** ☐ 15-lead ECG • CBC, Renal Panel, Calcium, Magnesium, Phosphorous, Random Glucose • TSH (if not done in last 3 months) • high sensitivity Troponin • INR (if on warfarin) ☐ CXR (PA and lateral) ☐ CXR portable
	Mobility ☐ Activity as tolerated ☐ Other ___________
	Consults / Referrals ☐ Cardiac Device Clinic if pacemaker or ICD present ☐ Other ___________
	Nutrition ☐ NPO for possible cardioversion ☐ Cardiac diet as tolerated ☐ Other ___________
	Observation / Treatment • Continuous cardiac monitoring • Vital signs q15min • Saline lock IV • Weight

Date & Time	Practitioner Signature:
	Practitioner Name (printed):

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Medication

NOTE: Ensure Medication Reconciliation Form has been reviewed

- **CHOOSE** RATE control **OR** RHTYHM control
- Assess for stroke and systemic embolism prevention in ALL patients

☐ **RATE CONTROL**

Goal resting HR less than 100 bpm and asymptomatic

Intravenous Therapy (select one of the following):

☐ metoprolol ________ mg (usual dose 2.5 to 5 mg) IV x 1
  ☐ Repeat at 2 to 5 min intervals up to 2 doses if HR over 120 bpm & SBP over 100 mmHg

OR

☐ dilTIAZem ________ mg (usual dose 0.25 mg/kg) IV x 1
  ☐ Repeat ______mg (usual dose 0.35 mg/kg) x 1 at 15 min interval if HR over 120 bpm & SBP over 100 mmHg

OR

☐ digoxin 0.5 mg IV x 1
  ☐ Repeat digoxin 0.25 mg IV q6h up to 2 doses if HR over 120 bpm

OR

☐ Other: ____

Oral Therapy (may give first dose at time of IV if SBP over 100 mmHg or give at _______)

☐ metoprolol 25 mg PO BID OR ☐ metoprolol 50 mg PO BID
☐ bisoprolol 2.5 mg PO daily OR ☐ bisoprolol 5 mg PO daily
☐ digoxin 0.125 mg PO daily
☐ dilTIAZem CD 120 mg PO daily OR ☐ dilTIAZem CD 180 mg PO daily
☐ Other: ____

☐ **RHYTHM CONTROL - CARDIOVERSION ORDERS**

- Assess for anticoagulation for stroke prevention in ALL patients (including $CHADS_2$ = 0)
- Consult the Cardiologist on Call for advice on management if one of the following contraindications to Non-Emergent Acute Cardioversion (High Risk for TIA/CVA) exist:
  - Recent Stroke or TIA (past 6 months
  - Mechanical Heart Valve
  - History of Rheumatic Mitral Stenosis
  - Unreliable history of onset **OR** onset of symptoms more than 48 hours ago (in a non-anticoagulated patient)
  - If on warfarin and sub-therapeutic INR in the preceding 3 weeks
  - If on dabigatran or rivaroxaban or apixaban and non-compliant with anticoagulation in the last 3 weeks

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☐ **CHEMICAL Cardioversion (select one of the following):**

☐ procainamide 1 gram IV over 60 minutes x 1 (success rate approximately 50%)

- Monitor for hypotension – notify MD if SBP less than 100 mmHg
- Monitor for prolonged QTc – notify MD if greater than 460 msec
- Monitor QRS – hold infusion and notify MD if QRS width increases by greater than 50%

*****OR*****

☐ propafenone and rate-controlling (AV nodal blocking) agent combination therapy

- ☐ metoprolol ______mg (Usual dose 25-50 mg) PO X 1 30 min PRIOR to taking propafenone

OR

- ☐ dilTIAZem IR _______mg (Usual dose 30-60 mg) PO X 1 30 min PRIOR to taking propafenone

AND THEN

- propafenone _______mg (Usual dose 600 mg in 70 kg or greater and 450 mg if less than 70 kg) PO x 1 (Contraindicated in patients with CAD/structural heart disease/reduced EF/significant sinus bradycardia or conduction system disease). Monitor patient 4 to 6 hours after dose.

☐ **ELECTRICAL Cardioversion**

- In the event a patient with a cardiac device needs cardioversion:
  if patient stable, call Cardiac Device Clinic clinician to be present for cardioversion
  if patient unstable, call Cardiac Device Clinic post cardioversion to interrogate the device
- Place Quick Combo pads on Anterior and Posterior Chest, ensure at least 10 cm away from Pacemaker or ICD
- Draw up medications for procedural sedation – **Do Not Administer**. All selected medications will be administered and titrated by treating physician. Ensure airway management equipment and personnel (eg: respiratory therapist) are available per departmental practices.
  - ☐ fentaNYL _____________ micrograms (usual dose 100 micrograms) IV x 1
  - ☐ propofol _______ mg (usual dose 0.5-1 mg/kg) IV x 1
  - ☐ ketamine _____________ mg (usual dose 0.5-1 mg/kg) IV x 1
  - ☐ midazolam ____________ mg (usual dose 5 mg) IV x 1
  - ☐ naloxone _____________ mg (usual dose 0.4 mg) IV x 1
  - ☐ Other: ____
- Set Defibrillator to 'SYNC'. Re-SYNC defibrillator or ensure in SYNC mode between shocks.
- Set Initial Energy to 150 J OR ☐ ___________ J
- If unsuccessful, consult the Cardiologist on Call for advice on management

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- **STROKE and SYSTEMIC EMBOLISM PREVENTION** **(select one of the following):**

CHADS65 (see appendix)____________ CrCl _________ mL/min

CrCl cutoffs for use: apixaban = 25 mL/min, rivaroxaban and dabigatran = 30 mL/min. Rivaroxaban may be used with caution down to CrCl 15mL/min; however, there is limited clinical data to support use in this degree of renal impairment and these patients do not qualify for Exception Drug Status

☐ apixaban 5 mg PO BID **OR** ☐ apixaban 2.5 mg PO BID (only if 2 of 3: Age 80 or greater, weight 60 kg or less, Scr 133 umol/L or greater)
☐ dabigatran 150 mg PO BID **OR** ☐ dabigatran 110 mg PO BID (if: Age 80 or greater, or age 75 or greater & 1 or more bleeding risk factor)
☐ rivaroxaban 20 mg PO daily with food **OR** ☐ rivaroxaban 15 mg PO daily with food (if CrCl 15-49 mL/min)
☐ warfarin ________ mg PO daily x _______ days, then per INR. Target INR 2-3 (2.5-3.5 if mechanical valve)
☐ ASA 81 mg enteric coated PO daily (normally not given in addition to OAC unless additional indication)
☐ Discontinue ASA – suggested when starting oral anticoagulant in absence of additional indication for ongoing ASA
☐ Other (Therapeutic LMWH or IV heparin): ________________________________

Discharge Planning

☐ Discharge home
☐ Obtain pre-discharge ECG
- Give patient education and discharge instruction package Thrombosis Canada – You Have Atrial Fibrillation, Apixaban, Dabigatran, Rivaroxaban, Warfarin, and ASA patient handouts (follow hyperlink or these handouts can be found on thrombosiscanada.ca under Patient & Family)

☐ Give discharge prescriptions to patient (rate/rhythm control & anticoagulation)
☐ If no physician available for follow-up, refer to local anticoagulation (warfarin) management service
  ☐ In Regina area, refer to RQHR Anticoagulation Management Service (AMS) to follow up warfarin management *after* initial AMS visit → FAX completed/signed AMS Patient Referral Form found on Nursing Home page under Anticoagulation Mgt tab. Call for initial appointment (306-766-6470) and provide to patient.
☐ Give discharge lab requisitions to patient (e.g. INR, serum creatinine, etc)

- Follow-up in office with Primary Health Practitioner (or walk-in if PHP not available) on date:

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Primary Health Practitioner to assess:
- ☐ INR/provide warfarin dosing
- ☐ Serum creatinine if on dabigatran, rivaroxaban, or apixaban
- ☐ Reassess anticoagulation therapy choice
- ☐ Ensure medications/dosing sufficiently controlling HR
- ☐ Other: ____

Outpatient Referral (Please consult primary cardiologist if patient already has a cardiologist)
- Fax ER record, order set & 12-lead ECGs to primary care provider and consultant if referral checked off below
- ☐ Consult Internal Medicine – MD to complete referral
- ☐ Consult Cardiology – MD to complete referral
- ☐ Consult Cardiac Electrophysiology (for consideration of AF ablation/rhythm control strategy) – MD to complete referral
- Outpatient ECHO – re: AF (if not done in last 6 months)
  Last ECHO date_______________
- ☐ Outpatient Holter if not previously completed
- ☐ Other: ____

Other

Date & Time	**Practitioner Signature:**
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