GW | Cardiac Surgery
THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

ECMO Activation for ICU Team

Attending or Fellow should contact CT AP RF 6060.
CT AP will call CT Surgeon on-call (see Web Exchange for Cardiac Surgical Services) or ECMO Coordinator (Mel Ricks 202-290-0960)

INFO NEEDED:

- ☐ Name
- ☐ Age
- ☐ Weight/ Height
- ☐ Allergies
- ☐ Pertinent Past Medical History
- ☐ Indication for ECMO
- ☐ Last Known Neuro Exam

- ☐ **Once decision is made to proceed, patient is to be moved to ICU 2 unless cardiac surgery attending deems unstable for transfer.**

- ☐ **Please print cores report for patient and give to AP**

- ☐ **Type and Cross for 4 units PRBCs and have in cooler at patient's bedside**
  (If unavailable, immediately *Emergency Release* 4 units of PRBCs)

- ☐ Preoxygenate on 100% FiO2 and maximize vasopressors and inotropes to maintain vitals

- ☐ Place order for 10,000 units Heparin for IV push to bedside for cannulation (ECMO team will administer as patient goes on pump)

- ☐ Please have doppler, sonosite and gel in the room with sterile cover

- ☐ Inform ECMO team about existing location of venous and arterial access

- ☐ Please obtain additional central venous access at left IJ unless contraindicated,(right IJ will be switched to Venous cannulation site.)

When the ECMO Team arrives their primary focus will be placing the patient on ECMO as rapidly as possible. Fellow or ICU attending must manage patient care and needs to remain at bedside. All orders for bedside nurses will come from you.

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ECMO Activation Nurse's Worksheet

- ☐ Primary nurse remains at bedside/ asks for additional help
- ☐ Please have 4 units PRBCs to bedside in cooler and ***checked*** with primed tubing attached to IV
- ☐ Have Thermacore™ at bedside
- ☐ Call pharmacy to request 10,000 units Heparin to be tubed STAT to remain at bedside **(DO NOT GIVE)**
- ☐ Pull ECMO Med Kit from pyxis in ICU2

MIX THE FOLLOWING, PLACE ON PUMP AND ATTACH TO OPEN IV LINE:

- 8MG EPI/ 250ML NS
- 20 UNITS VASO/ 100ML NS
- 8MG LEVO/ 250ML NS
- 20MG NEO/ 250ML NS

- ☐ Neo Stick/ Calcium Chloride/ Sodium Bicarb available
- ☐ Mark pulses/ Keep Doppler in room
- ☐ ISTAT with ABG with Lactate cartridges at bedside
- ☐ Suction available
- ☐ Place extensions on tubing to keep out of sterile field (team will be working from right side, access to right radial aline will not be available)
- ☐ Have one main IV line of NS to administer drugs
- ☐ Have Dolphin bed and PUP available in room

1. I, _____ (, or _____ as ☐ Parent ☐ Guardian ☐ Representative (Check One) acting on his/her behalf,) request the procedure/operation/treatment set out below.

2. I have requested Dr(s). _____ perform and supervise my procedure/operation/treatment which has been explained to me to be:

_____

_____

My doctor's explanation informed me about my medical condition as well as the common foreseeable benefits and risks of the procedure/operation/treatment as well as of its reasonable alternatives, if any.

3. I know, too, that during my procedure/operation/treatment it may become apparent to my doctor that in his/her professional judgement further procedures, operations, or treatments may be necessary. I therefore authorize modification or extension of this consent to include those additional procedures which in my doctor's professional judgement are medically necessary under these special circumstances and for my benefit with the exception of (check one): ☐ type of procedure _____ ☐ no exceptions

4. I understand that if a member of the Department of Anesthesiology is to participate in my care, for general, regional, or monitored anesthesia care, a separate consent will be obtained for these services.

5. If my doctor has indicated to me that I will require a local anesthetic as part of my procedure/operation/treatment, I authorize its administration. I acknowledge that my doctor has explained the benefits and risks of my receiving a local anesthetic as well as a reasonable alternative, if any. Potential risks may include but are not limited to pain at the injection site, or very rarely allergic reaction to the anesthetic. Further, I understand that during my procedure/operation/treatment, unforeseen circumstances may require alternative methods of anesthesia, such as general, and I therefore authorize modification of anesthesia administration which my doctor's professional judgement indicates to be necessary under the circumstances.

6. If it is anticipated that I may require transfusion of blood or blood products during my procedure, I will be required to sign a separate INFORMED CONSENT TO BLOOD TRANSFUSION AND/OR BLOOD COMPONENT ADMINISTRATION form. If in the event of an unanticipated emergency during my operative care and based on the medical judgement of my physician, I require the transfusion of blood or blood products, I understand they will be administered and agree to such action being taken.

7. Knowing that the George Washington University Hospital is a teaching institution, I understand that along with my doctor and his/her assistants and designees, other Hospital personnel such as residents, trainees, nurses, and technicians will be involved in my procedure/operation/treatment and care. I understand and agree to the presence of appropriate observers for the advancement of medical education and care.

8. I consent to the appropriate disposal of any tissue or part removed from my body and to the taking of photographs during the procedure/operation/treatment for research, teaching, or scientific purposes as long as my identity is not disclosed.

9. I agree to the appropriate disposal of any tissue or part removed from my body, to the taking of photographs during the procedure/operation/treatment for research, teaching, or scientific purposes as long as my identity is not disclosed, and to participate in the _____ _____ research protocol/program.

10. This procedure involves placement of a metal clip to mark the location of the biopsy: _____ Patient's Initials

PATIENT AFFIRMATION

By signing this request form, I am indicating that I understand the contents of this document and agree to its provisions. I know that if I have concerns or would like more detailed information, I can ask more questions and get more information from my attending physician. I am also acknowledging that I know that the practice of anesthesiology, medicine and surgery is not an exact science and that no one has given me any promises or guarantees about the designated procedure/operation/treatment or its results. I fully understand what I am now signing of my own free will.

WITNESS TO AFFIRMATION AND SIGNATURE	DATE	TIME	PATIENT SIGNATURE (or Parent, Guardian or Representative)	DATE/TIME

Signature of physician obtaining consent if other than physician performing procedure _____ **Date** _____ **Time** _____

PHYSICIAN ATTESTATION

I attest that this patient or the representative named above has been informed about the common foreseeable risks and benefits of undergoing the procedure as well as its reasonable alternative(s), if any. Further questions with regard to this procedure have been answered to his/her apparent satisfaction.

PHYSICIAN'S NAME - PRINTED	PHYSICIAN SIGNATURE	DATE/TIME

THE GEORGE WASHINGTON UNIVERSITY **HOSPITAL**

CO4026

PATIENT'S REQUEST FOR PROCEDURE, OPERATION AND TREATMENT

76-519 (4/15)

Patient Label

1. I, _____ or _____ ☐ Parent ☐ Guardian ☐ Representative (Check One)

understand that I may need a transfusion of blood or blood components during my hospitalization or course of treatment.

2. My doctor has explained the potential risks of receiving the blood transfusion and/or blood component, the anticipated benefits of the blood transfusion and/or blood component, and the risks that may occur if I do not receive the blood transfusion and/or blood component. I have also been told about other possible treatments and their risks and benefits.

3. I understand that blood transfusion and/or blood component administrations are given to replace important elements normally found in the blood. Red blood cells and whole blood are given so that vital organs (such as the heart, brain, kidneys, liver, etc.) can receive enough oxygen. If these organs do not receive enough oxygen, they may be so severely damaged as to cause death. Platelets, fresh frozen plasma, cryoprecipitate, and special components (such as factor VIII and factor IX concentrates) are given to prevent uncontrollable bleeding. Such uncontrolled bleeding can cause direct damage to vital organs (such as bleeding into the brain) or result in shock, where not enough oxygen is delivered to many organs, which can be severe enough to cause death. Other special blood components, such as coagulation factors, have their own risks and benefits that have been explained to me by my physician if they are needed.

4. I understand that harmful reactions to blood transfusion are very rare, although the most serious complications can result in death. Complications include but are not limited to allergic reactions, rashes, itching, bruises or bleeding or pain at the IV site, muscle pain or cramps, chest pain, nausea, headaches, fainting or dizziness, shortness of breath, fever, and chills. Although blood is carefully tested, there is a very small risk of getting AIDS, and a small chance of getting hepatitis, CMV and other viruses, as well as various bacteria, which may cause sepsis or blood poisoning. Other complications include but are not limited to destruction of blood cells, blood clots, uncontrollable bleeding, shock, kidney failure, fluid overload, and lung or heart failure.

5. I understand that it might be possible to donate my own blood for elective procedures, but this does not prevent all risks, such as bacterial contamination. In addition, previously donated autologous units may not be available or adequate for transfusion needs.

6. I understand that it might be possible to arrange for friends or relatives to donate blood for me. I understand that such donors may not be safer than regular volunteer blood donors and that the blood may not be available in adequate amounts for my transfusion requirements.

7. I have been given an opportunity to ask questions about my condition, alternatives to blood transfusion and/or blood component administration, the risks of not being transfused, and the hazards and risks of being transfused. I believe I have sufficient information to make an informed decision to consent to these transfusions as ordered by my physician.

8. This consent is good for all transfusions deemed necessary during this hospitalization or course of treatment, unless noted below.

PATIENT AFFIRMATION I am also acknowledging that I am satisfied with the explanation I have been given about my need for blood transfusions and/or blood products. I fully understand what I am now signing of my own free will.

WITNESS TO AFFIRMATION	SIGNATURE	DATE/TIME	PATIENT SIGNATURE (or Parent, Guardian or Representative)	SIGNATURE	DATE/TIME

Signature of physician obtaining consent if other than physician performing procedure _____ **Date** _____ **Time** _____

PHYSICIAN ATTESTATION I attest that this patient or the representative named above has been informed about the common foreseeable risks and benefits of undergoing the procedure as well as its reasonable alternative(s), if any. Further questions with regard to this procedure have been answered to his/her apparent satisfaction.

PHYSICIAN'S NAME - PRINTED	PHYSICIAN SIGNATURE	DATE/TIME

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

UHS Universal Health

CO4017

INFORMED CONSENT TO BLOOD TRANSFUSION AND/OR BLOOD COMPONENT ADMINISTRATION

76-521 (7/14)

Patient Label