PRE-THROMBOLYSIS CHECKLIST

PATIENT INFORMATION

Ambulance Service of New South Wales

Patient Health Care Record | Incident Number | Date (D D M M Y Y) | Car Number

Title | Patient's Family Name | M / F | Date of Birth | Patient Postcode

Patient's Given Name | Patient's Middle Name

CHECKLIST

	☑ Tick the box for a positive response		Comments
1	ST Elevation myocardial infarction has been identified by the central decision making point from your transmitted 12 Lead ECG.	☐	
2	The patient is conscious and orientated to time, place and person.	☐	
3	The patient has confirmed that the symptoms started less than 6 hours ago.	☐	
4	Pulse rate more than 50 bpm and less than 150 bpm. Systolic BP less than 180mmHg and Diastolic BP less than 110mmHg	☐	
5	The patient has confirmed that they have not had a previous diagnosed allergy, hypersensitivity or adverse reaction to clot dissolving drugs, such as Metalyse or to heparin, plavix and clexane.	☐	
6	The patient has complained of non-traumatic chest pain or other symptoms consistent with acute coronary syndrome / myocardial infarction	☐	
7	The patient has confirmed that she is not pregnant, nor has given birth within the last two weeks.	☐	
8	The patient has confirmed that they have not had a bleeding gastric ulcer within the last 6 months.	☐	
9	The patient has confirmed that they have not had a stroke of any sort including TIAs within the last 12 months and does not have a permanent disability from a previous stroke.	☐	
10	The patient has confirmed that they do not have an active or suspected bleeding or known bleeding tendency and has not had recent blood loss (except for normal menstruation).	☐	
11	The patient has confirmed that they are not taking warfarin (coumadin) or any other anticoagulant therapy.	☐	
12	The patient has confirmed that they have not had any surgical operation, tooth extractions, significant trauma requiring hospital admission or head injury within the last 4 weeks.	☐	
13	The patient has confirmed that they have not been treated recently for any serious head or brain condition, including cerebral tumor/s.	☐	
14	The patient has confirmed that they do not have a confirmed diagnosis of liver failure or renal failure.	☐	

DO NOT initiate the Thrombolysis Procedure unless all 14 boxes are ticked

Office Copy - Blue / Medical Review Copy - Pink / Hospital Copy - Grey Authorised by Paul Middleton, Chair, Clinical Advisory Committee. Issued Dec 2007

PATIENT INFORMATION

PROVISION OF INFORMATION TO PATIENT - to be read to the patient exactly as stated

Your ECG (heart tracing), has been transmitted to a Senior Heart Specialist who has identified that you are suffering from a heart attack. Your treatment options include a clot busting drug TENECTEPLASE and drugs that reduce new clot formation called ENOXAPARIN and CLOPIDOGREL.

The sooner you receive these drugs, the lower your risk of dying from this heart attack – which is why doctors recommend that the treatment is started as soon as possible.

The likely benefits of using these drugs are much greater than the risks.

Treatment at this stage improves the chances of surviving by approximately 25% but it can sometimes cause serious side effects. The biggest risk is potentially life-threatening stroke which affects up to 2 patients in every 100 patients. Significant bleeding which is not normally life threatening can occur in about 4 in 100 patients. Some patients also have allergic reactions and other side effects that do not usually cause any major problem.

PATIENT CONSENT

PATIENT CONSENT

> The paramedic has advised me that I am having a heart attack and has read the information above to me.
> I understand that I will be given an injection of a clot dissolving drug and that this treatment carries some risks as described in the information above.
> I request and consent to the treatment described above for me.

We wish to follow your progress. To do this we will require access to your hospital record for information relating to this procedure and a health representative may also wish to contact you. Your information will be kept strictly confidential.

> I give permission for the Ambulance Service of New South Wales to access my hospital record for information relating to this procedure and I agree to be contacted. I understand that I can withdraw my permission at any time.

Patient Consent Signature (Patient/Guardian) — PRINT NAME — SIGNATURE

Patient Decline Signature (Patient/Guardian) — PRINT NAME — SIGNATURE

PARAMEDIC & HOSPITAL SIGNATURES

PARAMEDIC DECLARATION

I, Paramedic: ..... have read the information above to the patient which informs the patient of their condition, the treatment offered and the material risks of receiving the thrombolysis treatment.

Paramedic Signature — PRINT NAME — SIGNATURE | Employee No.

Time of Administration — DATE — TIME

Receiving Hospital Handover Signature — PRINT NAME — SIGNATURE

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