

Telemetry Authorization Form Howard University Hospital

This form must be filled out by medical services ordering or renewing telemetry.

Check all indications for Telemetry Monitoring below:

*This form should not be part of the official medical record.

Class I (must be renewed after 72 hours):

	Syncope with one of the following: congestive heart failure, ventricular tachycardia, systolic blood pressure less than 90, second or third degree heart block, heart rate less than 45, or heart rate greater than 120
	Asymptomatic second or third degree heart block
	New onset atrial fibrillation/flutter, uncontrolled chronic atrial fibrillation/flutter, or sustained ventricular tachycardia
	Post-operative patients with one of the following: angina, new EKG changes, positive pre-operative stress test, systolic blood pressure less than 90, or heart rate greater than 130
	Initiation of antiarrhythmic medications
	Monitoring while adjusting antiarrhythmic medications
	Drug toxicity with arrhythmia
	External pacemaker

Class II (must be renewed after 48 hours):

	Acute myocardial infarction, chest pain, rule out myocardial infarction, or unstable angina
	Decompensated congestive heart failure
	Syncope with normal physical exam, normal EKG, or previously normal echocardiogram
	Post-operative patients with one of the following: previous history of coronary artery bypass graft(s), percutaneous coronary intervention(s), or valve repair/replacement
	Symptomatic bradycardia (heart rate less than 45) or symptomatic tachycardia (heart rate greater than 120)
	Cardiac contusion
	Major ischemic or hemorrhagic strokes (with potential for arrhythmia)
	Myocarditis or pericarditis
	Step down from intensive care with recent cardiac or respiratory arrest

Class III (must be renewed after 24 hours):

	Post coronary angiography, post ablation/cardioversion, or post defibrillator/pacemaker placement
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Other Diagnosis (must be approved by medical director/3rd year on call; must be renewed after 24 hours):

	Other (list here):
	Justification for telemetry monitoring (list here):

Physician requesting telemetry: Name _____ Signature _____


Date _____ Time _____ AM / PM

Team or Service _____ Pager _____ Patient Location _____

Reviewed by:

_____ RN Date _____ Time _____ AM / PM

● Approved ● Denied by: _____ Physician Date _____ Time _____ AM / PM

	2041 Georgia Ave. NW Washington, DC 20060	PATIENT IMPRINT
C - 220D	TELEMETRY AUTHORIZATION FORM	