

<b>UMC Health System</b>  <b>CARD OPEN HEART IMMEDIATE POST-OP PLAN</b>	<b>Patient Label Here</b>
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**PHYSICIAN ORDERS**

**Diagnosis** \_\_\_\_\_

**Weight** \_\_\_\_\_ **Allergies** \_\_\_\_\_

**Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.**

**ORDER ORDER DETAILS**

**Patient Care**

**Vital Signs**  
 Per Unit Standards

**Central Venous Pressure Monitoring**  
 CVP Readings Every 30 minutes and Record

**Strict Intake and Output**  
 q1h  Per Unit Standards

**Warming Measures**  
 Apply Warming Blanket As Needed.

**Patient Activity**  
 Up in Chair, Bed Position: HOB Greater Than or Equal to 30 degrees, UP in Chair within 6-8 hours post-extubation. POD1 Up in Chair TID. POD2 Up in Chair QID

**Perform Range of Motion Exercises**  
 Perform ROM to: Both Upper Extremities, q2h, Every 2 hrs until extubated. DO NOT restrict use of patient's arms during routine activities. POD2 ROM to arms QID when pt up in chair.

**CV Epicardial Pacing Protocol**  
 \*\*\*See Reference Text\*\*\*

**Urinary Catheter Care**  
 Foley to gravity drainage

**Insert Gastric Tube**

**Flush Gastric Tube**  
 q2h with, 20 mL Free water

**Gastric Tube to Suction**  
 Method: Low Intermittent Suction

**Maintain Chest Tube**  
 Device: Wet, cm H2O suction 20, Every shift. Strip Chest Tube. Level Chest Tubes every shift.

**Bedside Pacemaker Settings**  
 Mode: DDD, Rate: 90, 20 mA, 0.5 mV, 20 mA, 2.0 mV, 170 mSec

**Discontinue Arterial Line**  
 D/C on POD #1 at 0600 if CI greater than 2, and Urine Output greater than 0.5 mL/kg/hr

**Discontinue PA Catheter (Discontinue Swan Ganz)**  
 D/C on POD #1 at 0600 if CI greater than 2, and Urine Output greater than 0.5 mL/kg/hr

**Communication**

**Notify Provider (Misc)**  
 Reason: Urine output less than 0.5 mL/kg/hr x 2 hours

**Dietary**

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ORDER	ORDER DETAILS
	<b>NPO Diet</b>
	<b>Oral Diet</b> <input type="checkbox"/> Clear Liquid Diet, Sips/Ice Chips after extubation <input type="checkbox"/> Advance as tolerated to Heart Healthy <input type="checkbox"/> Clear Liquid Diet, Advance as tolerated to Full Liquid
<b>IV Solutions</b>	
	<b>1/2 NS</b> <input type="checkbox"/> IV, 75 mL/hr <input type="checkbox"/> IV, 150 mL/hr <input type="checkbox"/> IV, 125 mL/hr <input type="checkbox"/> IV, 200 mL/hr
<b>Medications</b>	
<b>Medication sentences are per dose. You will need to calculate a total daily dose if needed.</b>	
	<b>cefuroxime (Zinacef)</b> <input type="checkbox"/> 1.5 g, IVPush, inj, q8h, x 5 dose, Pre-OP/Post-Op Prophylaxis Give the 2nd dose 8 hours after the pre-op dose was given Reconstitute with 16 mL of Sterile Water or NS Administer Slow IV Push over 3-5 minutes.
	<b>vancomycin</b> <input type="checkbox"/> 1,000 mg, IVPB, ivpb, q12h, x 1 dose, Infuse over 90 min, Pre-OP/Post-Op Prophylaxis Start 12 hours after the initial pre-op dose given
	<b>mupirocin topical (mupirocin 2% topical ointment)</b> <input type="checkbox"/> 1 app, intra-nasal, oint, BID Use until nasal C&S is negative or patient is dismissed.
<b>Anti Platelets</b>	
	<b>aspirin</b> <input type="checkbox"/> 325 mg, PO, tab, Daily, Begin six (6) hours after bleeding stops Begin 6 (six) hours after bleeding stops <input type="checkbox"/> 300 mg, rectally, supp, Daily, Begin six (6) hours after bleeding stops Begin 6 (six) hours after bleeding stops
<b>Analgesics</b>	
	Analgesia While Intubated <b>morphine</b> <input type="checkbox"/> 2 mg, Slow IVPush, inj, q1h, PRN pain-with sedation (scale 4-10) While Intubated <input type="checkbox"/> 4 mg, Slow IVPush, inj, q1h, PRN pain-with sedation (scale 4-10) While Intubated <input type="checkbox"/> 6 mg, Slow IVPush, inj, q1h, PRN pain-with sedation (scale 4-10) While Intubated <input type="checkbox"/> 10 mg, Slow IVPush, inj, q1h, PRN pain-with sedation (scale 4-10) While Intubated
	<b>midazolam</b> <input type="checkbox"/> 1 mg, IVPush, inj, q1h, PRN anxiety While Intubated <input type="checkbox"/> 2 mg, IVPush, inj, q1h, PRN anxiety While Intubated <input type="checkbox"/> 5 mg, IVPush, inj, q1h, PRN anxiety While Intubated

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ORDER	ORDER DETAILS
<b>Gastrointestinal Agents</b>	
	<b>sennosides-docusate</b> <input type="checkbox"/> 1 tab, PO, tab, Nightly Give when tolerating PO
<b>Anti-pyretics</b>	
	<b>acetaminophen</b> <input type="checkbox"/> 650 mg, rectally, supp, q4h, PRN fever, For fever over 100.5 Give for Temp greater than 100.5 Do not exceed 4000 mg of acetaminophen per day from all sources. <input type="checkbox"/> 650 mg, rectally, supp, q4h, PRN fever, For fever over 101.5 Give for Temp greater than 101.5 Do not exceed 4000 mg of acetaminophen per day from all sources.
<b>Other Medications</b>	
	Replace volume as clinically indicated with 5% albumin in early post-op period (up to 3 hrs). If large volumes are required, change to normal saline after 1500 mL of albumin have been given  <b>albumin human (Albuminar-5)</b> <input type="checkbox"/> 12.5 g, IVPB, ivpb, as needed, PRN hypovolemia, x 24 hr, Infuse over 1 hr, Card Surg (post-op volume resuscitation) For volume up to 1500 mL. Use for hypovolemia in early post-op period (Up to 3 hours).
	<b>LR (Lactated Ringer's)</b> <input type="checkbox"/> IV, mL/hr For volume up to _____ mL.
	<b>aminocaproic acid</b> <input type="checkbox"/> 10 g, IVPB, iv set, ONE TIME Mix in 250 mL NS <input type="checkbox"/> 20 g, IVPB, iv set, ONE TIME Mix in 250 mL NS
	<b>aminocaproic acid 8 g/400 mL NS</b> <input type="checkbox"/> IV, x 6 hr Infuse x 6 (six) hours post-op Final concentration: 20 mg/mL. <input type="checkbox"/> Start at rate: _____ g/hr
	<b>bumetanide</b> <input type="checkbox"/> 1 mg, IVPush, inj, ONE TIME, PRN other, x 1 dose If urine output is less than 30 mL/hr for two (2) consecutive hours
<b>Laboratory</b>	
	<b>CBC with Differential</b> <input type="checkbox"/> STAT
	<b>Prothrombin Time with INR</b> <input type="checkbox"/> STAT
	<b>PTT</b> <input type="checkbox"/> STAT

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ORDER	ORDER DETAILS
	<b>Basic Metabolic Panel</b> <input type="checkbox"/> STAT
	<b>Magnesium Level</b> <input type="checkbox"/> STAT
	<b>Phosphorus Level</b> <input type="checkbox"/> STAT
<b>Diagnostic Tests</b>	
	<b>EKG-12 Lead</b> <input type="checkbox"/> Perform when temp 37 degrees Celsius; with any Rhythm changes.
	<b>EKG-12 Lead</b> <input type="checkbox"/> Every AM, while patient is in ICU
	<b>DX Chest Portable</b>
<b>Respiratory</b>	
	<b>Arterial Blood Gas</b> <input type="checkbox"/> STAT, Additional Tests: K+ (Potassium)   Ca++ (Ionized Calcium), All parameters should be drawn to correct ETCO2 SaO2 and document the SVO2
	<b>Arterial Blood Gas</b> <input type="checkbox"/> Routine, q24h, Continue while patient is on vent.
	<b>Ventilator Settings (Vent Settings)</b>
<b>Physical Medicine and Rehab</b>	
	***If the patient requires Traditional Sternal Precautions please uncheck "Move in the Tube" on both the PT and OT orders and check "Sternal Precautions".***
	<b>Consult PT Mobility for Eval &amp; Treat</b> <input type="checkbox"/> Other, Move in the Tube Education Post Cardiac Surgery
	<b>Consult PT Mobility for Eval &amp; Treat</b> <input type="checkbox"/> Other, Sternal Precaution Education Post Cardiac Surgery
	<b>Consult Occ Therapy for Eval &amp; Treat (Consult OT for Eval &amp; Treat)</b> <input type="checkbox"/> Other, Move in the Tube Education Post Cardiac Surgery
	<b>Consult Occ Therapy for Eval &amp; Treat (Consult OT for Eval &amp; Treat)</b> <input type="checkbox"/> Other, Sternal Precaution Education Post Cardiac Surgery
<b>Consults/Referrals</b>	
	<b>Consult Dietitian for Diet Education</b> <input type="checkbox"/> AHA, 2 Visits for AHA/Low Fat Diet Education
	<b>Consult Cardiac Rehab</b> <input type="checkbox"/> Inpatient Cardiac Rehab Phase I Treatment
	<b>Consult Cardiac Rehab</b> <input type="checkbox"/> Arrange and Evaluate Outpatient Phase I and Phase II Cardiac Rehab
	<b>Consult MD</b> <input type="checkbox"/> Service: Other : Hyperglycemic Management Team, Provider: Charlotte J. Harris, FNP, Reason: CV Surgery Insulin Order Management

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ORDER	ORDER DETAILS
	Consult MD <input type="checkbox"/> Service: Cardiology

...Additional Orders

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**PHYSICIAN ORDERS**

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ORDER	ORDER DETAILS
<b>Medications</b>	
Medication sentences are per dose. You will need to calculate a total daily dose if needed.	
<b>Antiarrhythmics</b>	
	<b>amiodarone 900 mg/500 mL D5W</b> <input type="checkbox"/> IV, See order comments Start at 1 mg/min IV x 6 hours (33 mL/hr) then decrease to 0.5 mg/min IV x 18 hours (17 mL/hr) <input type="checkbox"/> 900 mg, Every Bag
	Fixed Rate: <b>diltiazem 125 mg/125 mL NS - Fixed Rate</b> <input type="checkbox"/> IV, See order Comments Final concentration = 1 mg/mL. Provider order REQUIRED for ALL rate changes. <input type="checkbox"/> Start at rate: _____ mg/hr
<b>Antihypertensives</b>	
	Titratable: <b>nicardipine 25 mg/250 mL - Titratable</b> <input type="checkbox"/> IV, Maximum titration: 2.5 Titration units: mg/hr every every 5 minutes, Max dose: 15 mg/hr <input type="checkbox"/> Start at rate: _____ mg/hr
	Fixed Rate: <b>nicardipine 25 mg/250 mL NS - Fixed Rate</b> <input type="checkbox"/> IV <span style="margin-left: 150px;"><input type="checkbox"/> Start at rate: _____ mg/hr</span>
<b>Vasodilators</b>	
	Titratable: <b>milrinone 20 mg/100 mL D5W - Titratable</b> <input type="checkbox"/> IV, Max dose: 1 mcg/kg/min Final concentration = 0.2 mg/mL (200 mcg/mL). <input type="checkbox"/> Start at rate: _____ mcg/kg/min
	<b>nitroglycerin 50 mg/250 mL D5W - Titratable (nitroglycerin 50 mg/250 mL D5W - Titratable)</b> <input type="checkbox"/> IV, Max dose: 200 mcg/min Final concentration = 0.2 mg/mL (200 mcg/mL). <input type="checkbox"/> Start at rate: _____ mcg/min
	<b>nitropruside 50 mg/250 mL D5W - Titratable (nitropruside 50 mg/250 mL D5W - Titratable)</b> <input type="checkbox"/> IV, Max dose: 10 mcg/kg/min <span style="margin-left: 100px;"><input type="checkbox"/> Start at rate: _____ mcg/kg/min</span>
	Fixed Rate: <b>milrinone 20 mg/100 mL D5W - Fixed Rate</b> <input type="checkbox"/> IV, See order comments Final concentration = 0.2 mg/mL (200 mcg/mL). Provider order REQUIRED for ALL rate changes. <input type="checkbox"/> Start at rate: _____ mcg/kg/min
	<b>nitroglycerin 50 mg/250 mL D5W - Fixed R (nitroglycerin 50 mg/250 mL D5W - Fixed Rate)</b> <input type="checkbox"/> IV, See order comments Final concentration = 0.2 mg/mL (200 mcg/mL). Provider order REQUIRED for ALL rate changes. <input type="checkbox"/> Start at rate: _____ mcg/min

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ORDER	ORDER DETAILS
	<b>nitroPRUSSIDE 50 mg/250 mL D5W - Fixed R (nitroPRUSSIDE 50 mg/250 mL D5W - Fixed Rate)</b> <input type="checkbox"/> Start at rate: _____ mcg/kg/min <input type="checkbox"/> IV, See order comments
<b>Inotropes</b>	
	Titratable: <b>DOBUTamine 250 mg/250 mL D5W - Titratabl (DOBUTamine 250 mg/250 mL D5W - Titratable)</b> <input type="checkbox"/> IV, Max dose: 50 mcg/kg/min Final concentration = 1 mg/mL (1,000 mcg/mL). <input type="checkbox"/> Start at rate: _____ mcg/kg/min
	<b>DOPamine 400 mg/250 mL D5W - Titratable</b> <input type="checkbox"/> IV, Max dose: 50 mcg/kg/min Final concentration= 1.6 mg/mL (1,600 mcg/mL). <input type="checkbox"/> Start at rate: _____ mcg/kg/min
	<b>EPINEPHrine 4 mg/250 mL NS - Titratable</b> <input type="checkbox"/> IV, Max dose: 20 mcg/min Final concentration = 0.016 mg/mL (16 mcg/mL). <input type="checkbox"/> Start at rate: _____ mcg/min
	<b>norepinephrine 4 mg/250 mL NS - Titratab (norepinephrine 4 mg/250 mL NS - Titratable)</b> <input type="checkbox"/> IV, Max dose: 60 mcg/min Final concentration = 0.016 mg/mL (16 mcg/mL). <input type="checkbox"/> Start at rate: _____ mcg/min
	<b>phenylephrine 10 mg/250 mL NS - Titratab (phenylephrine 10 mg/250 mL NS - Titratable)</b> <input type="checkbox"/> IV, Max dose: 180 mcg/min Final concentration = 0.04 mg/mL (40 mcg/mL). <input type="checkbox"/> Start at rate: _____ mcg/min
	Fixed Rate: <b>DOBUTamine 250 mg/250 mL D5W - Fixed Rat (DOBUTamine 250 mg/250 mL D5W - Fixed Rate)</b> <input type="checkbox"/> IV, See order comments Final concentration = 1 mg/mL (1,000 mcg/mL). Provider order REQUIRED for ALL rate changes. <input type="checkbox"/> Start at rate: _____ mcg/kg/min
	<b>DOPamine 400 mg/250 mL D5W - Fixed Rate</b> <input type="checkbox"/> IV, See order comments Final concentration = 1.6 mg/mL (1600 mcg/mL). Provider order REQUIRED for ALL rate changes. <input type="checkbox"/> Start at rate: _____ mcg/kg/min
	<b>EPINEPHrine 4 mg/250 mL NS - Fixed Rate</b> <input type="checkbox"/> IV, See order comments Final concentration = 0.016 mg/mL (16 mcg/mL). Provider order REQUIRED for ALL rate changes. <input type="checkbox"/> Start at rate: _____ mcg/min
	<b>norepinephrine 4 mg/250 mL NS - Fixed Ra (norepinephrine 4 mg/250 mL NS - Fixed Rate)</b> <input type="checkbox"/> IV, See order comments Final concentration = 0.016 mg/mL (16 mcg/mL). Provider order REQUIRED for ALL rate changes. <input type="checkbox"/> Start at rate: _____ mcg/min

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ORDER	ORDER DETAILS
	<p>phenylephrine 10 mg/250 mL NS - Fixed Ra (phenylephrine 10 mg/250 mL NS - Fixed Rate)</p> <p><input type="checkbox"/> IV, See order comments</p> <p>Final concentration = 0.04 mg/mL (40 mcg/mL). Provider order REQUIRED for ALL rate changes.</p> <p><input type="checkbox"/> Start at rate: _____ mcg/min</p>

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**PHYSICIAN ORDERS**

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	<b>Patient Care</b> <b>Perform Bladder Scan</b> <input type="checkbox"/> Scan PRN, If more than 250, Then: Call MD, Perform as needed for patients complaining of urinary discomfort and/or bladder distention present OR 6 hrs post Foley removal and patient has not voided.
	<b>Medications</b> <b>Medication sentences are per dose. You will need to calculate a total daily dose if needed.</b>
	<b>menthol-benzocaine topical (Chloraseptic 6 mg-10 mg mucous membrane lozenge)</b> <input type="checkbox"/> 1 lozenge, mucous membrane, lozenge, q4h, PRN sore throat
	<b>dextromethorphan-guaiFENesin (dextromethorphan-guaiFENesin 20 mg-200 mg/10 mL oral liquid)</b> <input type="checkbox"/> 10 mL, PO, liq, q4h, PRN cough
	<b>dexamethasone-diphenhydrAMIN-nystatin-NS (Fred's Brew)</b> <input type="checkbox"/> 15 mL, swish & spit, liq, q2h, PRN mucositis While awake
	<b>Anti-pyretics</b> Select only ONE of the following for fever <b>acetaminophen</b> <input type="checkbox"/> 500 mg, PO, tab, q4h, PRN fever ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*** <input type="checkbox"/> 1,000 mg, PO, tab, q6h, PRN fever ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***
	<b>ibuprofen</b> <input type="checkbox"/> 200 mg, PO, tab, q4h, PRN fever Do not exceed 3,200 mg in 24 hours. Give with food. <input type="checkbox"/> 400 mg, PO, tab, q4h, PRN fever Do not exceed 3,200 mg in 24 hours. Give with food.
	<b>Analgesics for Mild Pain</b> Select only ONE of the following for mild pain <b>acetaminophen</b> <input type="checkbox"/> 500 mg, PO, tab, q6h, PRN pain-mild (scale 1-3) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*** <input type="checkbox"/> 1,000 mg, PO, tab, q6h, PRN pain-mild (scale 1-3) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*** <input type="checkbox"/> 650 mg, rectally, supp, q4h, PRN pain-mild (scale 1-3) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***
	<b>ibuprofen</b> <input type="checkbox"/> 400 mg, PO, tab, q6h, PRN pain-mild (scale 1-3) ***Do not exceed 3,200 mg of ibuprofen from all sources in 24 hours***. Give with food.
	<b>Analgesics for Moderate Pain</b> Select only ONE of the following for moderate pain

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ORDER	ORDER DETAILS
	<b>HYDROcodone-acetaminophen (HYDROcodone-acetaminophen 5 mg-325 mg oral tablet)</b> <input type="checkbox"/> 1 tab, PO, tab, q4h, PRN pain-moderate (scale 4-7) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*** <input type="checkbox"/> 2 tab, PO, tab, q4h, PRN pain-moderate (scale 4-7) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***
	<b>acetaminophen-codeine (acetaminophen-codeine (Tylenol with Codeine) 300 mg-30 mg oral tablet)</b> <input type="checkbox"/> 1 tab, PO, tab, q4h, PRN pain-moderate (scale 4-7) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*** <input type="checkbox"/> 2 tab, PO, tab, q4h, PRN pain-moderate (scale 4-7) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***
	<b>traMADol</b> <input type="checkbox"/> 50 mg, PO, tab, q6h, PRN pain-moderate (scale 4-7) <input type="checkbox"/> 50 mg, PO, tab, q4h, PRN pain-moderate (scale 4-7)
	<b>ketorolac</b> <input type="checkbox"/> 15 mg, IVPush, inj, q6h, PRN pain-moderate (scale 4-7), x 48 hr ***May give IM if no IV access***
<b>Analgesics for Severe Pain</b>	
	Select only ONE of the following for severe pain <b>morphine</b> <input type="checkbox"/> 2 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 8-10) <input type="checkbox"/> 4 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 8-10)
	<b>HYDROmorphine</b> <input type="checkbox"/> 0.2 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 8-10) <input type="checkbox"/> 0.4 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 8-10) <input type="checkbox"/> 0.6 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 8-10)
<b>Antiemetics</b>	
	Select only ONE of the following for nausea/vomiting <b>promethazine</b> <input type="checkbox"/> 25 mg, PO, tab, q4h, PRN nausea/vomiting
	<b>ondansetron</b> <input type="checkbox"/> 4 mg, IVPush, soln, q8h, PRN nausea/vomiting
<b>Gastrointestinal Agents</b>	
	Select only ONE of the following for constipation <b>docusate</b> <input type="checkbox"/> 100 mg, PO, cap, Nightly, PRN constipation
	<b>bisacodyl</b> <input type="checkbox"/> 10 mg, rectally, supp, Daily, PRN constipation
<b>Antacids</b>	
	<b>Al hydroxide-Mg hydroxide-simethicone (aluminum hydroxide-magnesium hydroxide-simethicone 200 mg-200 mg-20 mg/5 mL oral suspension)</b> <input type="checkbox"/> 30 mL, PO, susp, q4h, PRN indigestion Administer 1 hour before meals and nightly.

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ORDER	ORDER DETAILS
	<b>simethicone</b> <input type="checkbox"/> 80 mg, PO, tab chew, q4h, PRN gas <span style="margin-left: 200px;"><input type="checkbox"/> 160 mg, PO, tab chew, q4h, PRN gas</span>
<b>Anxiety</b>	
	Select only ONE of the following for anxiety <b>ALPRAZolam</b> <input type="checkbox"/> 0.25 mg, PO, tab, TID, PRN anxiety
	<b>LORazepam</b> <input type="checkbox"/> 0.5 mg, IVPush, inj, q6h, PRN anxiety <span style="margin-left: 200px;"><input type="checkbox"/> 1 mg, IVPush, inj, q6h, PRN anxiety</span>
<b>Insomnia</b>	
	Select only ONE of the following for insomnia <b>ALPRAZolam</b> <input type="checkbox"/> 0.25 mg, PO, tab, Nightly, PRN insomnia
	<b>LORazepam</b> <input type="checkbox"/> 2 mg, PO, tab, Nightly, PRN insomnia
	<b>zolpidem</b> <input type="checkbox"/> 5 mg, PO, tab, Nightly, PRN insomnia may repeat x1 in one hour if ineffective
<b>Antihistamines</b>	
	<b>diphenhydrAMINE</b> <input type="checkbox"/> 25 mg, PO, cap, q4h, PRN itching <span style="margin-left: 200px;"><input type="checkbox"/> 25 mg, IVPush, inj, q4h, PRN itching</span>
<b>Anorectal Preparations</b>	
	Select only ONE of the following for hemorrhoid care <b>witch hazel-glycerin topical (witch hazel-glycerin 50% topical pad)</b> <input type="checkbox"/> 1 app, topical, pad, as needed, PRN hemorrhoid care Wipe affected area
	<b>mineral oil-petrolatum-phenylephrine top (Preparation H 14%-74.9%-0.25% rectal ointment)</b> <input type="checkbox"/> 1 app, rectally, oint, q6h, PRN hemorrhoid care Apply to affected area

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<b>UMC Health System</b>  ELECTROLYTE MED PLAN - ICU ONLY	Patient Label Here
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**PHYSICIAN ORDERS**

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
<b>Communication</b>	
	<b>ICU Only - Adult Electrolyte Replacement (ICU Only - Adult Electrolyte Replacement Guidelines)</b> <input type="checkbox"/> T;N, See Reference Sheet
	Check below to select the Aggressive Potassium, phosphate, and magnesium. May then uncheck any replacement orders not wanted.  <b>Communication Order</b> <input type="checkbox"/> T;N
<b>Medications</b>	
	<b>Medication sentences are per dose. You will need to calculate a total daily dose if needed.</b>  Replacement orders should only be used in patients with a serum creatinine LESS than 2 mg/dL, and urinary output GREATER than 0.5 mL/kg/hr  IV POTASSIUM CHLORIDE REPLACEMENT:  Select only ONE of the following potassium chloride replacement orders - Aggressive or Non-Aggressive  AGGRESSIVE IV POTASSIUM REPLACEMENT - Replacement doses for potassium levels 3.6 mMol/L to 3.9 mMol/L:  <b>potassium chloride</b> <input type="checkbox"/> 20 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 2 hr, K+ level 3.6 - 3.9 mMol/L If K+ level 3.6 - 3.9 mMol/L - Administer 20 mEq KCl ivpb  Administer at 10 mEq/hr and repeat serum potassium level 2 hours after total replacement is completed.  Notify provider and check magnesium level if potassium deficiency does not correct after two replacement attempts.
	<b>potassium chloride</b> <input type="checkbox"/> 40 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 4 hr, If K+ level 3.1 - 3.5 mMol/L If K+ level 3.1 - 3.5 mMol/L - Administer 40 mEq KCl ivpb  Administer at 10 mEq/hr, and repeat serum potassium level 2 hours after total replacement is completed.  Notify provider and check magnesium level if potassium deficiency does not correct after two replacement attempts.
	<b>potassium chloride</b> <input type="checkbox"/> 60 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 6 hr, K+ level less than 3.1 mMol/L If K+ level less than 3.1 mMol/L -Administer 60 mEq KCl ivpb, and CONTACT PROVIDER.  Administer at 10 mEq/hr, and repeat serum potassium level 2 hours after total replacement is completed.  Notify provider and check magnesium level if potassium deficiency does not correct after two replacement attempts.  Continued on next page....

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<b>UMC Health System</b>  <b>ELECTROLYTE MED PLAN - ICU ONLY</b>	<b>Patient Label Here</b>
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**PHYSICIAN ORDERS**

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	<p>NON-AGGRESSIVE IV POTASSIUM REPLACEMENT - Replacement doses for potassium levels LESS than or equal to 3.5 mMol/L:</p> <p><b>potassium chloride</b></p> <p><input type="checkbox"/> 40 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 4 hr, If K+ level 3.1 - 3.5 mMol/L If K+ level 3.1 - 3.5 mMol/L - Administer 40 mEq KCl ivpb</p> <p>Administer at 10 mEq/hr, and repeat serum potassium level 2 hours after total replacement is completed.</p> <p>Notify provider and check magnesium level if potassium deficiency does not correct after two replacement attempts.</p>
	<p><b>potassium chloride</b></p> <p><input type="checkbox"/> 60 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 6 hr, K+ level less than 3.1 mMol/L If K+ level less than 3.1 mMol/L -Administer 60 mEq KCl ivpb, and CONTACT PROVIDER.</p> <p>Administer at 10 mEq/hr, and repeat serum potassium level 2 hours after total replacement is completed.</p> <p>Notify provider and check magnesium level if potassium deficiency does not correct after two replacement attempts.</p>
	<p>IV SODIUM PHOSPHATE REPLACEMENT: Use only when phosphorous needs replacement</p> <p>Select only ONE of the following sodium phosphate replacement orders - Aggressive or Non-Aggressive</p> <p>AGGRESSIVE IV SODIUM PHOSPHATE - Replacement doses for serum phosphorus levels equal to or LESS than 3.0 mg/dL AND serum sodium level LESS than 145 mMol/L.</p> <p><b>sodium phosphate</b></p> <p><input type="checkbox"/> 30 mmol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over 4 hr, For serum phosphorus level 1.0 - 3.0 mg/dL. If Phos level 1-3.0 mg/dL AND sodium level less than 145 mMol/L - Administer 30 mMol sodium phosphate.</p> <p>Repeat serum phosphorus level 6 hours after infusion completed.</p>
	<p><b>sodium phosphate</b></p> <p><input type="checkbox"/> 45 mMol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over 6 hr, For serum phosphorus level LESS than 1 mg/dL. If Phos level less than 1 mg/dL AND sodium level less than 145 mMol/L - Administer 45 mMol sodium phosphate and notify provider.</p> <p>Repeat serum phosphate level 6 hours after infusion completed.</p>
	<p>NON-AGGRESSIVE IV SODIUM PHOSPHATE REPLACEMENT: Select both sodium phosphate orders to replace phos levels LESS than or equal to 2.5 mg/dL</p> <p><b>sodium phosphate</b></p> <p><input type="checkbox"/> 30 mMol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over 4 hr, For serum phosphorus level 1-2.5 mg/dL. If Phos level 1 - 2.5 mg/dL AND sodium level less than 145 mMol/L - Administer 30 mMol sodium phosphate.</p> <p>Repeat serum phosphorus level 6 hours after infusion completed.</p> <p>Continued on next page....</p>

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<b>UMC Health System</b>  <b>ELECTROLYTE MED PLAN - ICU ONLY</b>	<b>Patient Label Here</b>
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**PHYSICIAN ORDERS**

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	<p><b>sodium phosphate</b></p> <p><input type="checkbox"/> 45 mMol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over 6 hr, For serum phosphorus level LESS than 1 mg/dL. If Phos level less than 1 mg/dL AND sodium level less than 145 mMol/L - Administer 45 mMol sodium phosphate and notify provider.</p> <p>Repeat serum phosphate level 6 hours after infusion completed.</p>
	<p>IV MAGNESIUM REPLACEMENT:</p> <p><b>magnesium sulfate</b></p> <p><input type="checkbox"/> 2 g, IVPB, ivpb, as needed, PRN hypomagnesemia, Infuse over 2 hr, For serum magnesium levels 1.6 - 1.9 mg/dL. If Mag level is 1.6 - 1.9 mg/dL - Administer 2 g mag sulfate.</p> <p>Administer at rate of 1 g/hr, and repeat serum magnesium level 2 hours after the infusion is completed.</p>
	<p><b>magnesium sulfate</b></p> <p><input type="checkbox"/> 4 g, IVPB, ivpb, as needed, PRN hypomagnesemia, Infuse over 4 hr, For serum magnesium levels equal to or LESS than 1.6 mg/dL. If Mag level is less than 1.6 mg/dL - Administer 4 g mag sulfate and NOTIFY PROVIDER if mag level is less than 1 mg/dL.</p> <p>Administer at rate of 1 g/hr, and repeat serum magnesium level 2 hours after the infusion is completed.</p>
	<p>IV POTASSIUM PHOSPHATE REPLACEMENT:</p> <p>Select only ONE of the following potassium phosphate replacement orders - Aggressive or Non-Aggressive. Nurse will contact provider for additional order IF potassium phosphate needed</p> <p>AGGRESSIVE IV POTASSIUM PHOSPHATE - Use when only phosphorus needs replacement with hypernatremia. Replacement doses for serum phosphorus levels LESS than or equal to 3.0 mg/dL AND serum sodium level GREATER than or equal to 145 mMol/L.</p> <p><b>Notify Provider (Misc) (Notify Provider of Results)</b></p> <p><input type="checkbox"/> Reason: Notify ordering provider of serum phosphorus level LESS than or equal to 3.0 mg/dL AND serum sodium level GREATER than or equal to 145 mMol/L, Use when only phosphorus needs replacement with hypernatremia.</p>
	<p>NON-AGGRESSIVE IV POTASSIUM PHOSPHATE REPLACEMENT - To replace phosphorus levels LESS than or equal to 2.5 mg/dL AND serum sodium level GREATER than or equal to 145 mMol/L.</p> <p><b>Notify Provider (Misc) (Notify Provider of Results)</b></p> <p><input type="checkbox"/> Reason: Notify ordering provider of serum phosphorus level LESS than or equal to 2.5 mg/dL AND serum sodium level GREATER than or equal to 145 mMol/L, Use when only phosphorus needs replacement with hypernatremia.</p>

Laboratory	
	Potassium Level
	Phosphorus Level
	Magnesium Level
	Sodium Level

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<b>UMC Health System</b> GERIATRIC DISCOMFORT MED PLAN	Patient Label Here
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**PHYSICIAN ORDERS**

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
<b>Patient Care</b>	
	<b>Perform Bladder Scan</b> <input type="checkbox"/> Scan PRN, If more than 250, Then: Call MD, Perform as needed for patients complaining of urinary discomfort and/or bladder distention present OR 6 hrs post Foley removal and patient has not voided.
<b>Medications</b>	
<b>Medication sentences are per dose. You will need to calculate a total daily dose if needed.</b>	
	<b>menthol-benzocaine topical (Chloraseptic 6 mg-10 mg mucous membrane lozenge)</b> <input type="checkbox"/> 1 lozenge, mucous membrane, lozenge, q4h, PRN sore throat
	<b>dextromethorphan-guaiFENesin (dextromethorphan-guaiFENesin 20 mg-200 mg/10 mL oral liquid)</b> <input type="checkbox"/> 10 mL, PO, liq, q4h, PRN cough
	<b>melatonin</b> <input type="checkbox"/> 2 mg, PO, tab, Nightly, PRN insomnia
<b>Analgesics for Mild Pain</b>	
	Select only ONE of the following for Mild Pain  <b>acetaminophen</b> <input type="checkbox"/> 500 mg, PO, tab, q6h, PRN pain-mild (scale 1-3) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*** <input type="checkbox"/> 1,000 mg, PO, tab, q6h, PRN pain-mild (scale 1-3) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*** <input type="checkbox"/> 650 mg, rectally, supp, q4h, PRN pain-mild (scale 1-3) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***
	<b>ibuprofen</b> <input type="checkbox"/> 400 mg, PO, tab, q6h, PRN pain-mild (scale 1-3) ***Do not exceed 3,200 mg of ibuprofen from all sources in 24 hours*** Give with food.
<b>Analgesics for Moderate Pain</b>	
	Select only ONE of the following for Moderate Pain  <b>HYDROcodone-acetaminophen (HYDROcodone-acetaminophen 5 mg-325 mg oral tablet)</b> <input type="checkbox"/> 1 tab, PO, tab, q4h, PRN pain-moderate (scale 4-7) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours ****
	<b>acetaminophen-codeine (acetaminophen-codeine (Tylenol with Codeine) 300 mg-30 mg oral tablet)</b> <input type="checkbox"/> 1 tab, PO, tab, q4h, PRN pain-moderate (scale 4-7) ***** Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*****
<b>Analgesics for Severe Pain</b>	
	Select only ONE of the following for Severe Pain  <b>morphine</b> <input type="checkbox"/> 2 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 8-10)
	<b>HYDROmorphone</b> <input type="checkbox"/> 0.2 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 8-10)
<b>Antiemetics</b>	

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<p><b>UMC Health System</b></p> <p>GERIATRIC DISCOMFORT MED PLAN</p>	<p>Patient Label Here</p>
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**PHYSICIAN ORDERS**

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	<p><b>ondansetron</b></p> <p><input type="checkbox"/> 4 mg, IVPush, soln, q8h, PRN nausea/vomiting</p>
	<p><b>Gastrointestinal Agents</b></p>
	<p>Select only ONE of the following for constipation</p> <p><b>docusate</b></p> <p><input type="checkbox"/> 100 mg, PO, cap, Nightly, PRN constipation</p>
	<p><b>bisacodyl</b></p> <p><input type="checkbox"/> 10 mg, rectally, supp, Daily, PRN constipation</p>
	<p><b>Antacids</b></p>
	<p><b>Al hydroxide-Mg hydroxide-simethicone (aluminum hydroxide-magnesium hydroxide-simethicone 200 mg-200 mg-20 mg/5 mL oral suspension)</b></p> <p><input type="checkbox"/> 30 mL, PO, susp, q4h, PRN indigestion Administer 1 hour before meals and nightly.</p>
	<p><b>simethicone</b></p> <p><input type="checkbox"/> 80 mg, PO, tab chew, q4h, PRN gas <span style="margin-left: 100px;"><input type="checkbox"/> 160 mg, PO, tab chew, q4h, PRN gas</span></p>
	<p><b>Anti-pyretics</b></p>
	<p>Select only ONE of the following for fever</p> <p><b>acetaminophen</b></p> <p><input type="checkbox"/> 500 mg, PO, tab, q4h, PRN fever ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***</p> <p><input type="checkbox"/> 1,000 mg, PO, tab, q6h, PRN fever ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***</p>
	<p><b>ibuprofen</b></p> <p><input type="checkbox"/> 200 mg, PO, tab, q4h, PRN fever ***Do not exceed 3,200 mg of ibuprofen from all sources in 24 hours*** Give with food.</p> <p><input type="checkbox"/> 400 mg, PO, tab, q4h, PRN fever ***Do not exceed 3,200 mg of ibuprofen from all sources in 24 hours*** Give with food.</p>
	<p><b>Anorectal Preparations</b></p>
	<p>Select only ONE of the following for hemorrhoid care</p> <p><b>witch hazel-glycerin topical (witch hazel-glycerin 50% topical pad)</b></p> <p><input type="checkbox"/> 1 app, topical, pad, as needed, PRN hemorrhoid care Wipe affected area</p>
	<p><b>mineral oil-petrolatum-phenylephrine top (Preparation H 14%-74.9%-0.25% rectal ointment)</b></p> <p><input type="checkbox"/> 1 app, rectally, oint, q6h, PRN hemorrhoid care Apply to affected area</p>

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<p><b>UMC Health System</b></p> <p>VTE PROPHYLAXIS PLAN</p>	<p>Patient Label Here</p>
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**PHYSICIAN ORDERS**

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS						
<b>Patient Care</b>							
	<p><b>VTE Guidelines</b></p> <p><input type="checkbox"/> See Reference Text for Guidelines</p>						
	<p>***If VTE Pharmacologic Prophylaxis not given, choose the Contraindications for VTE below and complete reason contraindicated***</p> <p><b>Contraindications VTE</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Active/high risk for bleeding</td> <td><input type="checkbox"/> Treatment not indicated</td> </tr> <tr> <td><input type="checkbox"/> Patient or caregiver refused</td> <td><input type="checkbox"/> Other anticoagulant ordered</td> </tr> <tr> <td><input type="checkbox"/> Anticipated procedure within 24 hours</td> <td><input type="checkbox"/> Intolerance to all VTE chemoprophylaxis</td> </tr> </table>	<input type="checkbox"/> Active/high risk for bleeding	<input type="checkbox"/> Treatment not indicated	<input type="checkbox"/> Patient or caregiver refused	<input type="checkbox"/> Other anticoagulant ordered	<input type="checkbox"/> Anticipated procedure within 24 hours	<input type="checkbox"/> Intolerance to all VTE chemoprophylaxis
<input type="checkbox"/> Active/high risk for bleeding	<input type="checkbox"/> Treatment not indicated						
<input type="checkbox"/> Patient or caregiver refused	<input type="checkbox"/> Other anticoagulant ordered						
<input type="checkbox"/> Anticipated procedure within 24 hours	<input type="checkbox"/> Intolerance to all VTE chemoprophylaxis						
	<p><b>Apply Elastic Stockings</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Apply to: Bilateral Lower Extremities, Length: Knee High</td> <td><input type="checkbox"/> Apply to: Left Lower Extremity (LLE), Length: Knee High</td> </tr> <tr> <td><input type="checkbox"/> Apply to: Right Lower Extremity (RLE), Length: Knee High</td> <td><input type="checkbox"/> Apply to: Bilateral Lower Extremities, Length: Thigh High</td> </tr> <tr> <td><input type="checkbox"/> Apply to: Left Lower Extremity (LLE), Length: Thigh High</td> <td><input type="checkbox"/> Apply to: Right Lower Extremity (RLE), Length: Thigh High</td> </tr> </table>	<input type="checkbox"/> Apply to: Bilateral Lower Extremities, Length: Knee High	<input type="checkbox"/> Apply to: Left Lower Extremity (LLE), Length: Knee High	<input type="checkbox"/> Apply to: Right Lower Extremity (RLE), Length: Knee High	<input type="checkbox"/> Apply to: Bilateral Lower Extremities, Length: Thigh High	<input type="checkbox"/> Apply to: Left Lower Extremity (LLE), Length: Thigh High	<input type="checkbox"/> Apply to: Right Lower Extremity (RLE), Length: Thigh High
<input type="checkbox"/> Apply to: Bilateral Lower Extremities, Length: Knee High	<input type="checkbox"/> Apply to: Left Lower Extremity (LLE), Length: Knee High						
<input type="checkbox"/> Apply to: Right Lower Extremity (RLE), Length: Knee High	<input type="checkbox"/> Apply to: Bilateral Lower Extremities, Length: Thigh High						
<input type="checkbox"/> Apply to: Left Lower Extremity (LLE), Length: Thigh High	<input type="checkbox"/> Apply to: Right Lower Extremity (RLE), Length: Thigh High						
	<p><b>Apply Sequential Compression Device</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Apply to Bilateral Lower Extremities</td> <td><input type="checkbox"/> Apply to Left Lower Extremity (LLE)</td> </tr> <tr> <td><input type="checkbox"/> Apply to Right Lower Extremity (RLE)</td> <td></td> </tr> </table>	<input type="checkbox"/> Apply to Bilateral Lower Extremities	<input type="checkbox"/> Apply to Left Lower Extremity (LLE)	<input type="checkbox"/> Apply to Right Lower Extremity (RLE)			
<input type="checkbox"/> Apply to Bilateral Lower Extremities	<input type="checkbox"/> Apply to Left Lower Extremity (LLE)						
<input type="checkbox"/> Apply to Right Lower Extremity (RLE)							
<b>Medications</b>							
<b>Medication sentences are per dose. You will need to calculate a total daily dose if needed.</b>							
	<p>VTE Prophylaxis: Trauma Dosing. For CrCl LESS than 30 mL/min, use heparin. Pharmacy will adjust enoxaparin dose based on body weight.</p> <p><b>enoxaparin (enoxaparin for weight 40 kg or GREATER)</b></p> <p><input type="checkbox"/> 0.5 mg/kg, subcut, syringe, q12h, Prophylaxis - Trauma Dosing, Pharmacy to Adjust Dose per Renal Function Pharmacy to use adjusted body weight if actual weight is greater than 20% of Ideal Body Weight</p>						
	<p><b>heparin</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> 5,000 units, subcut, inj, q12h</td> <td><input type="checkbox"/> 5,000 units, subcut, inj, q8h</td> </tr> </table>	<input type="checkbox"/> 5,000 units, subcut, inj, q12h	<input type="checkbox"/> 5,000 units, subcut, inj, q8h				
<input type="checkbox"/> 5,000 units, subcut, inj, q12h	<input type="checkbox"/> 5,000 units, subcut, inj, q8h						
	<p>VTE Prophylaxis: Non-Trauma Dosing</p> <p><b>enoxaparin (enoxaparin for weight 40 kg or GREATER)</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> 40 mg, subcut, syringe, q24h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function</td> </tr> <tr> <td><input type="checkbox"/> 30 mg, subcut, syringe, q12h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function</td> </tr> <tr> <td><input type="checkbox"/> 30 mg, subcut, syringe, q24h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function</td> </tr> <tr> <td><input type="checkbox"/> 40 mg, subcut, syringe, q12h, Prophylaxis - Non-Trauma Dosing, for BMI Greater than or Equal to 40 kg/m2, Pharmacy to Adjust Dose per Renal Function</td> </tr> </table>	<input type="checkbox"/> 40 mg, subcut, syringe, q24h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function	<input type="checkbox"/> 30 mg, subcut, syringe, q12h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function	<input type="checkbox"/> 30 mg, subcut, syringe, q24h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function	<input type="checkbox"/> 40 mg, subcut, syringe, q12h, Prophylaxis - Non-Trauma Dosing, for BMI Greater than or Equal to 40 kg/m2, Pharmacy to Adjust Dose per Renal Function		
<input type="checkbox"/> 40 mg, subcut, syringe, q24h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function							
<input type="checkbox"/> 30 mg, subcut, syringe, q12h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function							
<input type="checkbox"/> 30 mg, subcut, syringe, q24h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function							
<input type="checkbox"/> 40 mg, subcut, syringe, q12h, Prophylaxis - Non-Trauma Dosing, for BMI Greater than or Equal to 40 kg/m2, Pharmacy to Adjust Dose per Renal Function							
	<p><b>rivaroxaban</b></p> <p><input type="checkbox"/> 10 mg, PO, tab, In PM</p>						
	<p><b>warfarin</b></p> <p><input type="checkbox"/> 5 mg, PO, tab, In PM</p>						
	<p><b>aspirin</b></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> 81 mg, PO, tab chew, Daily</td> <td><input type="checkbox"/> 325 mg, PO, tab, Daily</td> </tr> </table>	<input type="checkbox"/> 81 mg, PO, tab chew, Daily	<input type="checkbox"/> 325 mg, PO, tab, Daily				
<input type="checkbox"/> 81 mg, PO, tab chew, Daily	<input type="checkbox"/> 325 mg, PO, tab, Daily						
	<p>Fondaparinux may only be used in adults 50 kg or GREATER. Prophylactic use is contraindicated in patients LESS than 50 kg or CrCl LESS than 30 mL/min</p> <p><b>fondaparinux</b></p> <p><input type="checkbox"/> 2.5 mg, subcut, syringe, q24h Prophylactic use is contraindicated in patients LESS than 50 kg or CrCl LESS than 30 mL/min</p>						

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 Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_