UMC Health System CARDIO POST CARDIAC/PERIPHERAL CATH PLAN		P	atient Label Here
Diama	-	AN ORDERS	
Diagnos			
Weight	Allergies	ND on "y" in the enceific ord	ler detail bey(as) where applicable
ORDER	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 DETAILS		
ORDER	Condition/Status		
	If this patient is an OUTPATIENT, you MUST place the Code Status order below:		
	Code Status Code Status: Full Code	Code Status: DNR/AND	(Allow Natural Death)
	Code Status: Care Limitation		
	Patient Care Continuous Telemetry (Intermediate Care)		
	Intermittent Telemetry		
	Daily Weight		
	Notify Nurse (DO NOT USE FOR MEDS) Check peripheral pulse and distal to the access site. If pulse is absent, verify with Doppler and check Cath Lab Op Record and Progress Notes to see if this is a new finding.		
	Notify Provider (Misc) Reason: If pulse is absent and extremity is cool, report to physician.		
	Notify Provider of VS Parameters SBP Greater Than 180, SBP Less Than 90, DBP Greater Than 110, DBP Less Than 60, MAP Less Than 60, HR Greater Than 110, HR Les Than 50		
	Notify Provider of VS Parameters		
	Strict Intake and Output		
	Vital Signs Per Unit Standards, Vital signs every 15 minutes x4 then every 30 m	inutes x2, then per unit standa	ards
	Insert Urinary Catheter	etention	
	Sheath/Access Site Management		
	Prior to Sheath Removal:		
	Patient Activity ☐ Bedrest, Bed Position: HOB Less Than or Equal to 30 degrees, with extremity straight while sheath in place. Prior to Sheath Removal:		
	POC ACT ☐ T;N Prior to Sheath Removal:		
	POC ACT ☐ Obtain ACT 2 hours after arrival to the unit. Notify provider of result. Prior to Sheath Removal: ☐ Obtain ACT @ Notify provider of results. Prior to Sheath Removal:		
🗆 то	Read Back	Scanned Powerchart	Scanned PharmScan
Order Take	on by Signature:	Date	Time
	Signature:		Time



CARDIO POST CARDIAC/PERIPHERAL CATH PLAN 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 DETAILS Connect Arterial Sheath to Pressure Moni (Connect Arterial Sheath to Pressure Monitor) Dir. Dir. Dir. Dir.<	UMC Health System		P	atient Label Here		
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	PHYSICIA			
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	er detail box(es) where applicable.	
ORDER	ORDER DETAILS			
	Notify Nurse (DO NOT USE FOR MEDS) If closure device fails, hold pressure and notify provider. After Sheath Removal:			
	Patient Activity ☐ Bedrest Post Cardiac Cath, Bed Position: HOB Less Than or Equal to 30 degrees, Flat time x3 hrs with leg straight after sheath has been pulled. After Sheath Removal: ☐ Bedrest Post Cardiac Cath, Bed Position: HOB Less Than or Equal to 30 degrees, Flat time x6 hrs with leg straight after sheath			
	 As been pulled. After Sheath Removal: Bedrest Post Cardiac Cath, Bed Position: HOB Less Than or Equal to 			
	has been pulled. After Sheath Removal: Bedrest Post Cardiac Cath, Bed Position: HOB Less Than or Equal to			
	Access) after sheath has been pulled. After Sheath Removal: Bedrest Post Cardiac Cath, Bed Position: HOB Less Than or Equal to 30 degrees, x hrs with arm/wrist straight (Radial/Brachial Access) after sheath has been pulled. After Sheath Removal:			
	Apply Compression Assist Device To: Access Site After Sheath Removal:			
	Radial Quick Clot Pressure Band Removal (Radial Quick Clot Pressu Procedure: Cath After Sheath Removal:	re Band Removal Instructio	ns)	
	After Flat Time Complete:			
	Discontinue Dressing Located: Access Site, Discontinue dressing in the AM. After Flat Time Complete:			
	Patient Activity ☐ Up Ad Lib/Activity as Tolerated, After SHEATH REMOVED and FLAT After Flat Time Complete:	TIME is COMPLETE		
	Dietary			
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Order Take	en by Signature:	Date	Time	
Physician Signature:		Date	Time	

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CARDIO POST CARDIAC/PERIPHERAL CATH PLAN			
	PHYSICIA		
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific or	der detail box(es) where applicable.
ORDER			
	Oral Diet Heart Healthy Diet Full Liquid Diet Clear Liquid Diet, Advance as tolerated to Regular Clear Liquid Diet, Advance as tolerated to Carbohydrate Controlled (1 Clear Liquid Diet, Advance as tolerated to Carbohydrate Controlled (2 Carbohydrate Controlled (1600 calories) Heart Healthy Diet Carbohydrate Controlled (2000 calories) Heart Healthy Diet	600 calories)	ce as tolerated to Heart Healthy
	NPO Diet		
	IV Solutions		
	NS IV, 50 mL/hr IV, 100 mL/hr IV, 150 mL/hr	☐ IV, 75 mL/hr ☐ IV, 125 mL/hr ☐ IV, 200 mL/hr	
	1/2 NS □ IV, 50 mL/hr □ IV, 100 mL/hr □ IV, 150 mL/hr	□ IV, 75 mL/hr □ IV, 125 mL/hr □ IV, 200 mL/hr	
	NS (NS bolus)	1,000 mL, IVPB, iv soln,	ONE TIME, Infuse over 1 hr
	Medications		
	Medication sentences are per dose. You will need to calculate a total daily dose if needed. nitroGLYCerin (nitroGLYCerin 0.4 mg sublingual tablet) 0.4 mg, SL, tab, q5min X 3, PRN chest pain		
	acetylcysteine (acetylcysteine (Mucomyst) 600 mg oral capsule)		
	Glycoprotein Ilb/Illa Inhibitors		
	Patient must be on telemetry while receiving tirofiban (Aggrastat)		
	Bolus (IF NOT GIVEN IN CATH LAB):		
	tirofiban ☐ 25 mcg/kg, IVPush, inj, ONE TIME, Use actual body weight even in ol IVPush over 5 minutes or less	oese patients.	
	Maintenance Infusion:		
	tirofiban 5 mg/100 mL IV, x 12 hr Final concentration = 0.05 mg/mL (50 mcg/mL). Usual maintenance dose is 0.15 mcg/kg/min. If creatinine clearance i **Patient must be on telemetry while receiving tirofiban (Aggrastat)** Continued on next page	s less than or equal to 60 ml	L/min, use 0.075 mcg/kg/min.
	Read Back	Scanned Powerchart	Scanned PharmScan
Order Take	en by Signature:	Date	Time_
Physician Signature:		·	

UMC Health System		Patient Label Here	
CARDIO POST CARDIAC/PERIPHERAL CATH PLA			
	BUVSICI	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice Al		
ORDER	ORDER DETAILS		
ORDER	Start at rate:mcg/kg/min		
	For patients with CrCl less than or equal to 60 mL/min, select tirofiban below to start at 0.075 mcg/kg/min		
	tirofiban 5 mg/100 mL □ IV, x 12 hr		
	Final concentration = 0.05 mg/mL (50 mcg/mL).		
	Usual maintenance dose is 0.15 mcg/kg/min. If creatinine clearance is less than or equal to 60 mL/min, use 0.075	nca/kg/min.	
	Patient must be on telemetry while receiving tirofiban (Aggrastat)		
	Start at rate:mcg/kg/min		
	Antithrombotics Bolus (IF NOT GIVEN IN CATH LAB):		
	bivalirudin		
	0.75 mg/kg, IVPush, inj, ONE TIME		
	Maintenance Infusion:		
	bivalirudin 250 mg/50 mL NS		
	\Box IV, x 4 hr Final concentration = 5 mg/mL.		
	Notify physician if administered dose (rate) is greater than the usual	lose range.	
	Start at rate:mg/kg/hr	-	
	For patients with CrCl less than or equal to 30 mL/min, select bivalirudir	below to start at 1 mg/kg/min	
	bivalirudin 250 mg/50 mL NS		
	\Box IV, x 4 hr Final concentration = 5 mg/mL.		
	Notify physician if administered dose (rate) is greater than the usual	lose range.	
	Start at rate:mg/kg/hr		
	P2Y12 Antagonist Loading Dose for IV Therapy (IF NOT GIVEN IN CATH LAB):		
	cangrelor		
	30 mcg/kg, IVPush, inj, ONE TIME		
	Administer rapidly over less than 1 minute.		
	Maintenance Dose for IV Therapy:		
	cangrelor 50 mg/250 mL NS - Percutaneous (cangrelor 50 mg/250 m	L <u>N</u> S - Percutaneous coronary intervention (PCI))	
	Start at rate:mcg/kg/min	IV, x 24 hr, Percutaneous Coronary Intervention (PCI)	
	Loading Dose for Oral Therapy (IF NOT GIVEN IN CATH LAB):		
	ticagrelor 180 mg, PO, tab, ONE TIME		
	prasugrel 60 mg, PO, tab, ONE TIME		
	clopidogrel 300 mg, PO, tab, ONE TIME 600 mg, PO, tab, ONE TIME		
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Order Take	n by Signature:	Date Time	
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CARDIO POST CARDIAC/PERIPHERAL CATH PLAN Presce 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 again 325 mg, PO, tab, ORT THE Multimatice Date for Oral Therapy: Licercifor	UMC Health System		Patient Label Here
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G 6.25 mg, PO, tab, BID Administer with breakfast and dinner. G 25 mg, PO, tab, BID Administer with breakfast and dinner. G 25 mg, PO, tab, BID Administer with breakfast and dinner. G 25 mg, PO, tab, BID Administer with breakfast and dinner. G entrainister with breakfast and dinner. G entrainications Beta Blocker Allergy or Sensitivity G entrainications Beta Block Corter Law Disease - Asthma G other (specify below in other reason) Ace Inhibitors G entrainication G other Taken by Signature: G entrainications G entrainication G entrain		25 mg, PO, tab sa, Daily	☐ 50 mg, PO, tab sa, Daily
2.5 mg, PO, tab, Daily 5 mg, PO, tab, Daily 20 mg, PO, tab, Daily 20 mg, PO, tab, Daily Contraindications Beta Blocker Bradycardia or Heart Block Chronic Lung Disease Asthma Bradycardia or Heart Block Other (specify below in other reason) Severe Hypotension Ace Inhibitors Isinopril 2.5 mg, PO, tab, Daily 5 mg, PO, tab, Daily 10 mg, PO, tab, Daily 5 mg, PO, tab, Daily 2.5 mg, PO, tab, Daily 5 mg, PO, tab, Daily 10 mg, PO, tab, Daily 5 mg, PO, tab, Daily 2.5 mg, PO, tab, Daily 50 mg, PO, tab, Daily 10 mg, PO, tab, Daily 50 mg, PO, tab, Daily 25 mg, PO, tab, Daily 50 mg, PO, tab, Daily 100 mg, PO, tab, Daily 50 mg, PO, tab, Daily 100 mg, PO, tab, Daily Date To Read Back Scanned Powerchart Scanned PharmScan Order Taken by Signature: Date Time		 6.25 mg, PO, tab, BID Administer with breakfast and dinner. 12.5 mg, PO, tab, BID Administer with breakfast and dinner. 25 mg, PO, tab, BID 	
Allergy or Sensitivity Bradycardia or Heart Block Chronic Lung Disease Asthma Severe Hypotension Other (specify below in other reason) Severe Hypotension Acc Inhibitors Isinopril 2.5 mg, PO, tab, Daily 10 mg, PO, tab, Daily 25 mg, PO, tab, Daily 25 mg, PO, tab, Daily 10 mg, PO, tab, Daily 10 mg, PO, tab, Daily 10 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily <td></td> <td>2.5 mg, PO, tab, Daily</td> <td>☐ 5 mg, PO, tab, Daily ☐ 20 mg, PO, tab, Daily</td>		2.5 mg, PO, tab, Daily	☐ 5 mg, PO, tab, Daily ☐ 20 mg, PO, tab, Daily
Iisinopril 5 mg, PO, tab, Daily 10 mg, PO, tab, Daily 20 mg, PO, tab, Daily Iosartan 25 mg, PO, tab, Daily 25 mg, PO, tab, Daily 50 mg, PO, tab, Daily 100 mg, PO, tab, Daily 50 mg, PO, tab, Daily		Allergy or Sensitivity Chronic Lung Disease Asthma	Bradycardia or Heart Block
Image: Signature: Signature: Image: Date State State <td< td=""><td></td><td>Ace Inhibitors</td><td></td></td<>		Ace Inhibitors	
Iosartan 0 50 mg, PO, tab, Daily 100 mg, PO, tab, Daily 50 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Daily 100 mg, PO, tab, Da		2.5 mg, PO, tab, Daily	
Order Taken by Signature: Date Time		losartan ☐ 25 mg, PO, tab, Daily	
Order Taken by Signature: Date Time			
	П то	Read Back	Scanned Powerchart Scanned PharmScan
	Order Take	en by Signature:	Date Time

UMC Health System			
CARDIO POST CARDIAC/PERIPHERAL CATH PLAN		Patient Label Here	
	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific order detail box(es) where applicable.	
ORDER	ORDER DETAILS		
	Contraindications ACEI or ARB Allergy to Both Angioedema Caused by an ACE or ARB Hypotension Renal Artery Stenosis Other (specify below in other reason)	 Allergy to One-Must Try the Other Hyperkalemia Moderate or Severe Aortic Stenosis Worsening Renal Function 	
	Lipid Management		
	atorvastatin 10 mg, PO, tab, Nightly 40 mg, PO, tab, Nightly pravastatin	☐ 20 mg, PO, tab, Nightly ☐ 80 mg, PO, tab, Nightly	
	10 mg, PO, tab, Nightly 40 mg, PO, tab, Nightly	 20 mg, PO, tab, Nightly 80 mg, PO, tab, Nightly 	
	rosuvastatin ☐ 5 mg, PO, tab, Nightly ☐ 20 mg, PO, tab, Nightly	☐ 10 mg, PO, tab, Nightly ☐ 40 mg, PO, tab, Nightly	
Contraindications Statins Hypersensitivity Liver disease or elevated transaminases		 Intolerance(myopathy, myalgia, myositis) Pregnancy or breastfeeding 	
	ezetimibe 10 mg, PO, tab, Daily		
Provider - PCSK9 inhibitor (Outpatient Consideration ONLY)			
_	Laboratory Click to review cardiac labs		
	Basic Metabolic Panel (BMP)		
	CBC		
	Comprehensive Metabolic Panel		
	D Dimer HS 500		
	Hemoglobin and Hematocrit		
	Hemoglobin and Hematocrit		
	Magnesium Level		
	Prothrombin Time with INR		
	PTT STAT		
П то	Read Back	Scanned Powerchart Scanned PharmScan	
Order Take	n by Signature:	Date Time	
Physician Signature:		Date Time	

	UMC Health System	P	Patient Label Here
C	ARDIO POST CARDIAC/PERIPHERAL CATH PLAN		
	PHYSICI	AN ORDERS	
	Place an "X" in the Orders column to designate orders of choice A		der detail box(es) where applicable.
ORDER	ORDER DETAILS		
	Troponin T High Sensitivity		
	Troponin T High Sensitivity Routine, T;N, q6h 4 times		
	Hemoglobin A1C		
	Lipid Panel ☐ Next Day in AM, T+1;0300, for 1 days		
	Phosphorus Level ☐ Next Day in AM, T+1;0300, for 1 days		
	Prothrombin Time with INR ☐ Next Day in AM, T+1;0300, for 1 days		
	PTT □ Next Day in AM, T+1;0300, for 1 days		
	Basic Metabolic Panel Next Day in AM, T+1;0300, for 3 days		
	CBC □ Next Day in AM, T+1;0300, for 3 days		
	Comprehensive Metabolic Panel		
	Magnesium Level ☐ Next Day in AM, T+1;0300, for 3 days		
	Anti Xa Level		
	POC Blood Sugar Check		
	Urine Random Drug Screen		
	Diagnostic Tests		
	Notify Nurse (DO NOT USE FOR MEDS)		
	Order EKG STAT if the patient begins to have chest pain		
	Order EKG STAT if the patient begins to have chest pain		
	EKG-12 Lead STAT, CAD Coronary Artery Disease, upon arrival to unit.		
	EKG-12 Lead T;N, Routine, CAD Coronary Artery Disease, Every AM for 3 days, In	AM	
	Echo Transthoracic (TTE) with contrast i (Echo Transthoracic (TTE)	with contrast if needed)	
	Limited Echo Transthoracic (Limited TTE)		
	DX Chest Portable		
Пто	Read Back	Scanned Powerchart	Scanned PharmScan
Order Take	en by Signature:	Date	Time
Physician	Signature:	Date	Time



UMC Health System CARDIO POST CARDIAC/PERIPHERAL CATH PLAN		Pat	ient Label Here
	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	r detail box(es) where applicable.
ORDER	ORDER DETAILS		
	DX Chest Portable T;N, Routine, Every 0300, for 1, days		
	VL LE Arterial/BG Bilat (Vascular Lab)		
	VL LE Arterial/BG Lt (Vascular Lab) Routine, Post procedure/Post stent follow up		
	VL LE Arterial/BG Rt (Vascular Lab) Routine, Post procedure/Post stent follow up		
	Respiratory		
	Respiratory Care Plan Guidelines		
	☐ Via: Nonrebreather mask, Keep sats greater than: 92%	☐ Via: Simple mask, Keep sa	ats greater than: 92%
	Physical Medicine and Rehab		
	Consult PT Mobility for Eval & Treat		
	Consult Speech Therapy for Eval & Treat Consults/Referrals		
	Consult Cardiac Rehab Cardiac Rehab for Inpatient Phase I evaluation and treatment. Arran treatment.	ge Outpatient Cardiac Rehab I	Phase II evaluation and
	Consult Supervised Exercise Therapy for (Consult Supervised Exercise Therapy for PAD for Inpatient Evaluation and Tre Supervised Exercise Therapy for PAD for Outpatient Evaluation and T	eatment	
	Additional Orders		
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		Date	Time
Physician Signature:			



	UMC Health System	P	itient Label Here
BB TYPE AND SCREEN PLAN			
	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN		er detail box(es) where applicable.
ORDER			
	Laboratory		
	BB Blood Type (ABO/Rh)		
	BB Antibody Screen		
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Order Take	en by Signature:	Date	Time
	Signature:		Time
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UMC Health System		Pa	atient Label Here
DISCOMFORT MED PLAN			
	DIMONIA		
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific ord	er detail box(es) where applicable.
ORDER	ORDER DETAILS Patient Care		
	Perform Bladder Scan		
	Scan PRN, If more than 250, Then: Call MD, Perform as needed for p distention present OR 6 hrs post Foley removal and patient has not vo		discomfort and/or bladder
	Medications		
	Medication sentences are per dose. You will need to calculate a tota menthol-benzocaine topical (Chloraseptic 6 mg-10 mg mucous mem 1 lozenge, mucous membrane, lozenge, q4h, PRN sore throat	-	
	dextromethorphan-guaiFENesin (dextromethorphan-guaiFENesin 20 ☐ 10 mL, PO, liq, q4h, PRN cough	mg-200 mg/10 mL oral liqu	id)
	dexamethasone-diphenhydrAMIN-nystatin-NS (Fred's Brew) ☐ 15 mL, swish & spit, liq, q2h, PRN mucositis While awake		
	Anti-pyretics		
	Select only ONE of the following for fever		
	acetaminophen 500 mg, PO, tab, q4h, PRN fever ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*** 1,000 mg, PO, tab, q6h, PRN fever ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***		
	- · ·		
	 ibuprofen 200 mg, PO, tab, q4h, PRN fever Do not exceed 3,200 mg in 24 hours. Give with food. ↓ 400 mg, PO, tab, q4h, PRN fever Do not exceed 3,200 mg in 24 hours. Give with food. 		
	Analgesics for Mild Pain		
	Select only ONE of the following for mild pain		
	acetaminophen ☐ 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*** ☐ 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*** ☐ 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***		
	ibuprofen ☐ 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.		
	Analgesics for Moderate Pain		
	Select only ONE of the following for moderate pain		
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Order Take	n by Signature:	Date	Time



	UMC Health System	Pat	ient Label Here
DI	ISCOMFORT MED PLAN		
	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific order	detail box(es) where applicable.
ORDER	ORDER DETAILS		
	HYDROcodone-acetaminophen (HYDROcodone-acetaminophen 5 mg-325 mg oral tablet)		
	1 tab, PO, tab, q4h, PRN pain-moderate (scale 4-6)		
	Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours		
	Do not exceed 4,000 mg of acetaminophen from all sources in 24 h	nours	
	acetaminophen-codeine (acetaminophen-codeine (Tylenol with Code 1 tab, PO, tab, q4h, PRN pain-moderate (scale 4-6)	eine) 300 mg-30 mg oral table	it)
	Do not exceed 4,000 mg of acetaminophen from all sources in 24 h	nours	
	2 tab, PO, tab, q4h, PRN pain-moderate (scale 4-6)		
	Do not exceed 4,000 mg of acetaminophen from all sources in 24 h	nours	
	traMADol		
		☐ 50 mg, PO, tab, q4h, PRN	pain-moderate (scale 4-6)
	<u>ke</u> torolac		
	15 mg, IVPush, inj, q6h, PRN pain-moderate (scale 4-6), x 48 hr		
	May give IM if no IV access		
	Analgesics for Severe Pain		
	Select only ONE of the following for severe pain		
morphine		_	
	2 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 7-10)	4 mg, Slow IVPush, inj, q4	n, PRN pain-severe (scale 7-10)
	HYDROmorphone	-	
	0.2 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 7-10) 0.6 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 7-10)	0.4 mg, Slow IVPush, inj, q	4h, PRN pain-severe (scale 7-10)
	Antiemetics		
	Select only ONE of the following for nausea/vomiting		
	promethazine		
	25 mg, PO, tab, q4h, PRN nausea/vomiting		
	ondansetron		
	☐ 4 mg, IVPush, soln, q8h, PRN nausea/vomiting		
	Gastrointestinal Agents		
	Select only ONE of the following for constipation		
	docusate		
	☐ 100 mg, PO, cap, Nightly, PRN constipation		
	bisacodyl		
	10 mg, rectally, supp, Daily, PRN constipation		
	Antacids		
	Al hydroxide-Mg hydroxide-simethicone (aluminum hydroxide-magn suspension)	esium nydroxide-simethicon	e 200 mg-200 mg-20 mg/5 mL orai
30 mL, PO, susp, q4h, PRN indigestion			
	Administer 1 hour before meals and nightly.		
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Physician Signature:		Date	Time



	UMC Health System	
וס	SCOMFORT MED PLAN	Patient Label Here
	PHYSICIA	N ORDERS
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific order detail box(es) where applicable.
ORDER	ORDER DETAILS	
	simethicone ☐ 80 mg, PO, tab chew, q4h, PRN gas	☐ 160 mg, PO, tab chew, q4h, PRN gas
	Anxiety	
	Select only ONE of the following for anxiety	
	ALPRAZolam 0.25 mg, PO, tab, TID, PRN anxiety	
	LORazepam □ 0.5 mg, IVPush, inj, q6h, PRN anxiety	☐ 1 mg, IVPush, inj, q6h, PRN anxiety
	Insomnia	
	Select only ONE of the following for insomnia	
	ALPRAZolam 0.25 mg, PO, tab, Nightly, PRN insomnia	
	LORazepam 2 mg, PO, tab, Nightly, PRN insomnia	
	zolpidem 5 mg, PO, tab, Nightly, PRN insomnia	
	may repeat x1 in one hour if ineffective	
	Antihistamines	
	diphenhydrAMINE 25 mg, PO, cap, q4h, PRN itching	25 mg, IVPush, inj, q4h, PRN itching
	Anorectal Preparations	
	Select only ONE of the following for hemorrhoid care	
	witch hazel-glycerin topical (witch hazel-glycerin 50% topical pad) ☐ 1 app, topical, pad, as needed, PRN hemorrhoid care Wipe affected area	
	mineral oil-petrolatum-phenylephrine top (Preparation H 14%-74.9%- 1 app, rectally, oint, q6h, PRN hemorrhoid care Apply to affected area	0.25% rectal ointment)
🗆 то	Read Back	Scanned Powerchart Scanned PharmScan
Order Take	en by Signature:	Date Time
Physician	Signature:	Date Time

ELECTROLYTE MED PLAN - ICU ONLY

	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	ID an "x" in the specific orde	er detail box(es) where applicable.
ORDER	ORDER DETAILS		
	Communication		
	ICU Only - Adult Electrolyte Replacement (ICU Only - Adult Electroly T;N, See Reference Sheet	te Replacement Guidelines)	
	Check below to select the Aggressive Potassium, phosphate, and magn May then uncheck any replacement orders not wanted.	esium.	
	Communication Order		
	Medications		
	Medication sentences are per dose. You will need to calculate a tot Replacement orders should only be used in patients with a serum creati GREATER than 0.5 mL/kg/hr	-	urinary output
	IV POTASSIUM CHLORIDE REPLACEMENT:		
	Select only ONE of the following potassium chloride replacement orders	- Aggressive or Non-Aggressi	ve
	AGGRESSIVE IV POTASSIUM REPLACEMENT - Replacement doses	for potassium levels 3.6 mMol	'L to 3.9 mMol/L:
	potassium chloride ☐ 20 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 2 hr, If K+ level 3.6 - 3.9 mMol/L - Administer 20 mEq KCl ivpb	K+ level 3.6 - 3.9 mMol/L	
	Administer at 10 mEq/hr and repeat serum potassium level 2 hours a	fter total replacement is compl	eted.
	Notify provider and check magnesium level if potassium deficiency do	es not correct after two replac	ement attempts.
	potassium chloride ☐ 40 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 4 hr, If K+ level 3.1 - 3.5 mMol/L - Administer 40 mEq KCl ivpb	lf K+ level 3.1 - 3.5 mMol/L	
	Administer at 10 mEq/hr, and repeat serum potassium level 2 hours a		
	Notify provider and check magnesium level if potassium deficiency do	bes not correct after two replac	ement attempts.
	potassium chloride ☐ 60 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 6 hr, If K+ level less than 3.1 mMol/L -Administer 60 mEq KCl ivpb, and CC Administer at 10 mEq/hr, and repeat serum potassium level 2 hours a	ONTACT PROVIDER.	leted.
	Notify provider and check magnesium level if potassium deficiency do Continued on next page	es not correct after two replac	ement attempts.
Пто	Read Back	Scanned Powerchart	Scanned PharmScan
Order Take	n by Signature:	Date	Time
Physician	Signature	Date	Time



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ELECTROLYTE MED PLAN - ICU ONLY

	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	er detail box(es) where applicable.
ORDER	ORDER DETAILS		
	NON-AGGRESSIVE IV POTASSIUM REPLACEMENT - Replacement de potassium chloride	oses for potassium levels LES	SS than or equal to 3.5 mMol/L:
	☐ 40 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 4 hr, I If K+ level 3.1 - 3.5 mMol/L - Administer 40 mEq KCl ivpb	f K+ level 3.1 - 3.5 mMol/L	
	Administer at 10 mEq/hr, and repeat serum potassium level 2 hours a	fter total replacement is comp	leted.
	Notify provider and check magnesium level if potassium deficiency do	es not correct after two replac	cement attempts.
	potassium chloride ☐ 60 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 6 hr, H If K+ level less than 3.1 mMol/L -Administer 60 mEq KCl ivpb, and CC		
	Administer at 10 mEq/hr, and repeat serum potassium level 2 hours a	fter total replacement is comp	leted.
	Notify provider and check magnesium level if potassium deficiency do	es not correct after two replac	cement attempts.
	IV SODIUM PHOSPHATE REPLACEMENT: Use only when phosphorou	s needs replacement	
	Select only ONE of the following sodium phosphate replacement orders	- Aggressive or Non-Aggressi	ve
	AGGRESSIVE IV SODIUM PHOSPHATE - Replacement doses for serul serum sodium level LESS than 145 mMol/L.	m phosphorus levels equal to	or LESS than 3.0 mg/dL AND
	sodium phosphate 30 mmol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over If Phos level 1-3.0 mg/dL AND sodium level less than 145 mMol/L - Ar		
	Repeat serum phosphorus level 6 hours after infusion completed.		
	sodium phosphate ☐ 45 mMol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse ove If Phos level less than 1 mg/dL AND sodium level less than 145 mMol		
	Repeat serum phosphate level 6 hours after infusion completed.		
	NON-AGGRESSIVE IV SODIUM PHOSPHATE REPLACEMENT: Select equal to 2.5 mg/dL	t both sodium phosphate orde	rs to replace phos levels LESS than or
	 sodium phosphate ☐ 30 mMol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over If Phos level 1 - 2.5 mg/dL AND sodium level less than 145 mMol/L - A 		0
	Repeat serum phosphorus level 6 hours after infusion completed. Continued on next page		
🗆 то	Read Back	Scanned Powerchart	Scanned PharmScan
Order Take	en by Signature:	Date	Time
	Signature:		

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ELECTROLYTE MED PLAN - ICU ONLY

	PHYSICIAN ORD	ERS	
	Place an "X" in the Orders column to designate orders of choice AND an ">	r" in the specific order"	detail box(es) where applicable.
ORDER	R ORDER DETAILS		
	sodium phosphate 45 mMol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over 6 hr, I If Phos level less than 1 mg/dL AND sodium level less than 145 mMol/L - Adr		
	Repeat serum phosphate level 6 hours after infusion completed.		
	IV MAGNESIUM REPLACEMENT:		
	magnesium sulfate □ 2 g, IVPB, ivpb, as needed, PRN hypomagnesemia, Infuse over 2 hr, For ser If Mag level is 1.6 - 1.9 mg/dL - Administer 2 g mag sulfate.	-	-
	Administer at rate of 1 g/hr, and repeat serum magnesium level 2 hours after	the infusion is complete	d.
	magnesium sulfate ☐ 4 g, IVPB, ivpb, as needed, PRN hypomagnesemia, Infuse over 4 hr, For ser If Mag level is less than 1.6 mg/dL - Administer 4 g mag sulfate and NOTIFY		
	Administer at rate of 1 g/hr, and repeat serum magnesium level 2 hours after	the infusion is complete	d.
	IV POTASSIUM PHOSPHATE REPLACEMENT:		
	Select only ONE of the following potassium phosphate replacement orders - Age contact provider for additional order IF potassium phosphate needed	gressive or Non-Aggress	sive. Nurse will
	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.		
	Notify Provider (Misc) (Notify Provider of Results) Reason: Notify ordering provider of serum phosphorus level LESS than or eq equal to 145 mMol/L, Use when only phosphorus needs replacement with hyperbolic series and the series of the se		erum sodium level GREATER than or
	NON-AGGRESSIVE IV POTASSIUM PHOSPHATE REPLACEMENT - To repla serum sodium level GREATER than or equal to 145 mMol/L.	ce phosphorus levels LE	ESS than or equal to 2.5 mg/dL AND
	Notify Provider (Misc) (Notify Provider of Results) Reason: Notify ordering provider of serum phosphorus level LESS than or eq equal to 145 mMol/L, Use when only phosphorus needs replacement with hy		erum sodium level GREATER than or
	Laboratory		
	Potassium Level		
	Phosphorus Level		
	Magnesium Level		
	Sodium Level		
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Order Take	aken by Signature:	Date	Time
Physician	n Signature:	Date	Time



	UMC Health System		
G	ERIATRIC DISCOMFORT MED PLAN	P	atient Label Here
	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific ord	ler detail box(es) where applicable.
ORDER	ORDER DETAILS		
	Patient Care		
	Perform Bladder Scan Scan PRN, If more than 250, Then: Call MD, Perform as needed for p distention present OR 6 hrs post Foley removal and patient has not ve		y discomfort and/or bladder
	Medications	al daily doop if pooded	
	Medication sentences are per dose. You will need to calculate a tot menthol-benzocaine topical (Chloraseptic 6 mg-10 mg mucous mem 1 lozenge, mucous membrane, lozenge, q4h, PRN sore throat		
	dextromethorphan-guaiFENesin (dextromethorphan-guaiFENesin 20	mg-200 mg/10 mL oral liqu	uid)
	melatonin 2 mg, PO, tab, Nightly, PRN insomnia		
	Analgesics for Mild Pain		
	Select only ONE of the following for Mild Pain		
	acetaminophen 500 mg, PO, tab, q6h, PRN pain-mild (scale 1-3) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 h 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 h		
	 ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 h 650 mg, rectally, supp, q4h, PRN pain-mild (scale 1-3) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 h 		
	ibuprofen ↓ 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.	**	
	Analgesics for Moderate Pain		
	Select only ONE of the following for Moderate Pain		
	HYDROcodone-acetaminophen (HYDROcodone-acetaminophen 5 m		
	Do not exceed 4,000 mg of acetaminophen from all sources in 24 h	nours *	
	acetaminophen-codeine (acetaminophen-codeine (Tylenol with Code 1 tab, PO, tab, q4h, PRN pain-moderate (scale 4-6) ***** Do not exceed 4,000 mg of acetaminophen from all sources in 2		plet)
	Analgesics for Severe Pain		
	Select only ONE of the following for Severe Pain		
	morphine 2 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 7-10)		
	HYDROmorphone 0.2 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 7-10)		
	Antiemetics		
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UMC Health System Patient Label Here	
GERIATRIC DISCOMFORT MED PLAN	
PHYSICIAN ORDERS	where englischie
Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) v ORDER ORDER DETAILS	where applicable.
ondansetron	
4 mg, IVPush, soln, q8h, PRN nausea/vomiting	
Gastrointestinal Agents	
Select only ONE of the following for constipation	
docusate 100 mg, PO, cap, Nightly, PRN constipation	
bisacodyl	
10 mg, rectally, supp, Daily, PRN constipation Antacids	
Antacios Al hydroxide-Mg hydroxide-simethicone (aluminum hydroxide-magnesium hydroxide-simethicone 200 mg-200 m	ng-20 mg/5 mL oral
suspension)	
30 mL, PO, susp, q4h, PRN indigestion Administer 1 hour before meals and nightly.	
simethicone	
Image: Solution of the solution	
Anti-pyretics	
Select only ONE of the following for fever	
acetaminophen 500 mg, PO, tab, q4h, PRN fever	
Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours	
 1,000 mg, PO, tab, q6h, PRN fever ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*** 	
ibuprofen	
200 mg, PO, tab, q4h, PRN fever	
Do not exceed 3,200 mg of ibuprofen from all sources in 24 hours Give with food.	
400 mg, PO, tab, q4h, PRN fever	
Do not exceed 3,200 mg of ibuprofen from all sources in 24 hours Give with food.	
Anorectal Preparations	
Select only ONE of the following for hemorrhoid care	
witch hazel-glycerin topical (witch hazel-glycerin 50% topical pad)	
1 app, topical, pad, as needed, PRN hemorrhoid care Wipe affected area	
mineral oil-petrolatum-phenylephrine top (Preparation H 14%-74.9%-0.25% rectal ointment)	
L 1 app, rectally, oint, q6h, PRN hemorrhoid care Apply to affected area	
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HEPARIN INFUSION MED PLAN

	PHYSICI	AN ORDERS	
	Place an "X" in the Orders column to designate orders of choice Al	ND an "x" in the specific orde	r detail box(es) where applicable.
ORDER	ORDER DETAILS		
	Patient Care		
	Heparin Infusion Nomogram ***See Reference Text***		
	Check the .Medication Management order below if the patient requires a provider. AntiXa levels must be used. aPTT levels will not be accepted		
	.Medication Management (Notify Nurse and Pharmacy) ☐ BID, Start date T;N DO NOT USE NOMOGRAM - Patient requires specific monitoring a aPTT levels will not be accepted for monitoring and heparin adjustment		vider. AntiXa levels must be used.
	Communication		
	Notify Nurse (DO NOT USE FOR MEDS) Obtain Xa Heparin (Anti-Xa) Level 6 hours after starting infusion and	6 hours after every rate change	Э.
	Notify Provider (Misc) Reason: 2 consecutive Xa Heparin (Anti-Xa) levels are greater than	0.9 or less than 0.2	
	Notify Provider (Misc) Reason: If platelet count decreases by 50% of baseline or drops belo	ow 100,000 (100 K/uL)	
	Notify Provider (Misc) Reason: If Hemoglobin decreases by 2 g/dL or more.		
	Notify Provider (Misc) Reason: If signs of bleeding occur.		
	Medications Medication sentences are per dose. You will need to calculate a to	tal daily dose if needed.	
	.Medication Management ☐ Start date T;N Discontinue all other orders for heparin products (i.e. heparin sububo	utaneous, enoxaparin).	
	Venous Thromboembolic Disorder		
	Deep Vein Thrombosis, Pulmonary Embolism		
	heparin 80 units/kg, IVPush, inj, ONE TIME For Load Dose: Indication: DVT/PE Recommended maximum dose	is 10,000 units.	
	heparin 25,000 units/250 mL D5W (Venous (heparin 25,000 units/250 IV Indication: DVT/PE. The initial maximum rate is 18 units/kg/hr not to on = 100 unit/mL. Refer to Heparin Infusion Nomogram for maintena specific adjustments. Continued on next page	exceed a total hourly dose of 1,	800 units. Final concentrati
		_	
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Order Take	n by Signature:	Date	Time
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	PHYSICIA	I ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN) an "x" in the specific order	detail box(es) where applicable.
ORDER	ORDER DETAILS		
	Start at rate:units/kg/hr		
	Cardiac Unstable angina, ST elevation MI, non-ST elevation MI		
	heparin 60 units/kg, IVPush, inj, ONE TIME Load Dose: Indication: units/kg, IVPush, inj, ONE TIME Load Dose: Indication: units/kg, IVPush, inj, ONE TIME	nmended maximum dose is 4,	000 units.
	heparin 25,000 units/250 mL D5W (Cardiac (heparin 25,000 units/250	nL D5W (Cardiac)) ☐ ।∨	
	Neurological		
	Ischemic strokes with a suspected embolic source in which thrombolytics cerebral hemorrhage	have NOT been given and a C	CT has confirmed NO
	No initial heparin load dose recommended.		
	 heparin 25,000 units/250 mL D5W (Neurolo (heparin 25,000 units/250 □ IV Indication: Ischemic Stroke. Initial maximum rate is 12 units/kg/hr not to concentration = 100 unit/mL. Refer to Heparin Infusion Nomogram for requires specific adjustments. 	o exceed a total hourly dose of	
	Start at rate:units/kg/hr		
	Laboratory		
	Laboratory Baseline Labs CBC STAT		
	Baseline Labs CBC		
	Baseline Labs CBC STAT Anti Xa Level		
	Baseline Labs CBC STAT Anti Xa Level STAT Prothrombin Time with INR (Protime with INR)		
	Baseline Labs CBC STAT Anti Xa Level STAT Prothrombin Time with INR (Protime with INR) STAT Daily Labs CBC		
	Baseline Labs CBC STAT Anti Xa Level STAT Prothrombin Time with INR (Protime with INR) STAT Daily Labs		
	Baseline Labs CBC STAT Anti Xa Level STAT Prothrombin Time with INR (Protime with INR) STAT Daily Labs CBC	Scanned Powerchart	Scanned PharmScan
	Baseline Labs CBC STAT Anti Xa Level STAT Prothrombin Time with INR (Protime with INR) STAT Daily Labs CBC Next Day in AM, T+1;0300, Every AM 3 days	Scanned Powerchart	



	UMC Health System		
PA	AIN MANAGEMENT - ALTERNATING SCHEDULED N	-	tient Label Here
		AN ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	ND an "x" in the specific orde	er detail box(es) where applicable.
ORDER	ORDER DETAILS Medications		
	Medication sentences are per dose. You will need to calculate a to	tal daily dose if needed.	
	The following scheduled orders will alternate every 3 hours.		
	 ibuprofen ☐ 400 mg, PO, tab, q6h, x 3 days To be alternated with acetaminophen every 3 hours. 		
	acetaminophen		
	☐ 500 mg, PO, tab, q6h, x 3 days To be alternated with ibuprofen every 3 hours. Do not exceed 4000 n	ng of acetaminophen per day f	rom all sources.
	For renally impared patients: The following scheduled orders will alterna	ate every 3 hours.	
	traMADol 50 mg, PO, tab, q6h, x 3 days		
	To be alternated with acetaminophen every 3 hours.		
	acetaminophen ☐ 500 mg, PO, tab, q6h, x 3 days To be alternated with tramadol every 3 hours. Do not exceed 4000 m	g of acetaminophen per day fr	om all sources.
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		Pa	tient Label Here	
	OTASSIUM CHLORIDE REPLACEMENT PLAN			
	PHYSICIA			
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific ord	er detail box(es) where applicable.	
ORDER				
	Patient Care			
	Potassium Replacement Guidelines T;N, See Reference Text			
	Medications			
	Medication sentences are per dose. You will need to calculate a tot	al daily dose if needed.		
	ORAL POTASSIUM REPLACEMENT			
	 potassium chloride 40 mEq, PO, tab sa, as needed, PRN hypokalemia Use oral replacement if patient is asymptomatic and able to take ORA replacement if ordered. 	L supplementation. If contrai	ndicated, give IV potassium	
	replacement il ordered.			
	If K+ level less than 3.1 mMol/L -Contact provider immediately as IV r If K+ level 3.1 - 3.5 mMol/L - Administer 40 mEq KCl oral. May give e if needed.			
	Repeat potassium level with next day labs.			
	IV POTASSIUM REPLACEMENT			
	 potassium chloride 40 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 4 hr, I If K+ level 3.1 - 3.5 mMol/L - Administer 40 mEq KCl ivpb Administer at 10 mEq/hr. Repeat serum potassium level 2 hours after 		ed.	
	potassium chloride			
	☐ 60 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 6 hr, I If K+ level less than 3.1 mMol/L -Administer 60 mEq KCl ivpb, and con Administer at 10 mEq/hr. Repeat serum potassium level 2 hours after	ntact provider		
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UMC Health System SLIDING SCALE INSULIN REGULAR PLAN		Patient Label Here	
		N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	er detail box(es) where applicable.
ORDER	ORDER DETAILS Patient Care		
	Poc Blood Sugar Check		
	Per Sliding Scale Insulin Frequency	AC & HS	
	AC & HS 3 days		
	BID a6h	☐ q12h ☐ q6h 24 hr	
	a q4h		
	Sliding Scale Insulin Regular Guidelines		
	Follow SSI Regular Reference Text		
	Medications Medication sentences are per dose. You will need to calculate a tot	al daily daga if peeded	
	insulin regular (Low Dose Insulin Regular Sliding Scale)	al dally dose il needed.	
	0-10 units, subcut, inj, AC & nightly, PRN glucose levels - see parame	eters	
	Low Dose Insulin Regular Sliding Scale		
	If blood glucose is less than 70 mg/dL and patient is symptomatic, init	iate hypoglycemia guidelines	and notify provider.
	70-150 mg/dL - 0 units		
	151-200 mg/dL - 1 units subcut		
	201-250 mg/dL - 2 units subcut		
	251-300 mg/dL - 3 units subcut		
	301-350 mg/dL - 4 units subcut 351-400 mg/dL - 6 units subcut		
	If blood glucose is greater than 400 mg/dL, administer 10 units subcut, notify provider, and repeat POC blood sugar check in 2 hours. Continue to repeat 10 units subcut and POC blood sugar checks every 2 hours until blood glucose is less than 300 mg/dL. Once the blood sugar is less than 300 mg/dL, repeat POC blood sugar in 4 hours and then resume normal POC blood sugar check and		
	insutlin regular sliding scale.		normal i oo blood sugar oncok and
	0-10 units, subcut, inj, BID, PRN glucose levels - see parameters		
	Low Dose Insulin Regular Sliding Scale		
	If blood glucose is less than 70 mg/dL and patient is symptomatic, init	iate hypoglycemia guidelines	and notify provider.
	70-150 mg/dL - 0 units		
	151-200 mg/dL - 1 units subcut		
	201-250 mg/dL - 2 units subcut		
	251-300 mg/dL - 3 units subcut		
	301-350 mg/dL - 4 units subcut 351-400 mg/dL - 6 units subcut		
	If blood glucose is greater than 400 mg/dL, administer 10 units subcu		
	hours. Continue to repeat 10 units subcut and POC blood sugar chec Once the blood sugar is less than 300 mg/dL, repeat POC blood suga		
	insutlin regular sliding scale.	ii in 4 nours and then resume	normal POC blood sugar check and
	Continued on next page		
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SLIDING SCALE INSULIN REGULAR PLAN

	PHYSIC	AN ORDERS		
	Place an "X" in the Orders column to designate orders of choice A	ND an "x" in the specific ord	er detail box(es) where applicable.	
ORDER	ORDER DETAILS			
ORDER	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 Of 0 units, subcut, inj, TID, PRN glucose levels - see parameters Low Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider. 70-150 mg/dL - 1 units subcut 201-250 mg/dL - 2 units subcut 201-250 mg/dL - 1 units subcut 201-250 mg/dL - 3 units subcut 301-350 mg/dL - 4 units subcut 301-350 mg/dL - 6 units subcut 301-350 mg/dL - 6 units subcut 301-350 mg/dL - 6 units subcut Once the blood sugar is less than 300 mg/dL, administer 10 units subcut, notify provider, and repeat POC blood sugar check an ontimit regular sliding scale If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider. 70-150 mg/dL - 0 units 151-200 mg/dL - 1 units subcut 201-250 mg/dL - 4 units subcut 201-200 mg/dL - 4 units subcut			
	If blood glucose is greater than 400 mg/dL, administer 10 units subo hours. Continue to repeat 10 units subcut and POC blood sugar che Once the blood sugar is less than 300 mg/dL, repeat POC blood su insutlin regular sliding scale. Continued on next page	ecks every 2 hours until blood g	glucose is less than 300 mg/dL.	
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SLIDING SCALE INSULIN REGULAR PLAN		P	atient Label Here		
	PHYSICIA	N ORDERS			
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific or	ler detail box(es) where applicable.		
ORDER	ORDER DETAILS				
	 insulin regular (Moderate Dose Insulin Regular Sliding Scale) □ 0-12 units, subcut, inj, AC & nightly, PRN glucose levels - see parame Moderate Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is symptomatic, init 		s and notify provider.		
	70-150 mg/dL - 0 units 151-200 mg/dL - 2 units subcut 201-250 mg/dL - 3 units subcut 251-300 mg/dL - 5 units subcut 301-350 mg/dL - 7 units subcut 351-400 mg/dL - 10 units subcut				
	 If blood glucose is greater than 400 mg/dL, administer 12 units subcu hours. Continue to repeat 10 units subcut and POC blood sugar che Once blood sugar is less than 300 mg/dl, repeat POC blood sugar in rinsutlin regular scale. □ 0-12 units, subcut, inj, BID, PRN glucose levels - see parameters Moderate Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is symptomatic, init 	cks every 2 hours until blood 4 hours and then resume nor	glucose is less than 300 mg/dL. mal POC blood sugar checks and		
	70-150 mg/dL - 0 units 151-200 mg/dL - 2 units subcut 201-250 mg/dL - 3 units subcut 251-300 mg/dL - 5 units subcut 301-350 mg/dL - 7 units subcut 351-400 mg/dL - 10 units subcut				
	If blood glucose is greater than 400 mg/dL, administer 12 units subcut, notify provider, and repeat POC blood sugar check in 2 hours. Continue to repeat 10 units subcut and POC blood sugar checks every 2 hours until blood glucose is less than 300 mg/dL. Once blood sugar is less than 300 mg/dl, repeat POC blood sugar in 4 hours and then resume normal POC blood sugar checks and insutlin regular scale. 0-12 units, subcut, inj, TID, PRN glucose levels - see parameters Moderate Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider.				
	70-150 mg/dL - 0 units 151-200 mg/dL - 2 units subcut 201-250 mg/dL - 3 units subcut 251-300 mg/dL - 5 units subcut 301-350 mg/dL - 7 units subcut 351-400 mg/dL - 10 units subcut				
	If blood glucose is greater than 400 mg/dL, administer 12 units subcut, notify provider, and repeat POC blood sugar check in 2 hours. Continue to repeat 10 units subcut and POC blood sugar checks every 2 hours until blood glucose is less than 300 mg/dL. Once blood sugar is less than 300 mg/dl, repeat POC blood sugar in 4 hours and then resume normal POC blood sugar checks and insutlin regular scale. Continued on next page				
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SLIDING SCALE INSULIN REGULAR PLAN

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		PHYSICIAN ORDERS	
	Place an "X" in the Orders column to designate orders o	f choice AND an "x" in the spec	ific order detail box(es) where applicable.
RDER	ORDER DETAILS		
	└ 0-12 units, subcut, inj, q6h, PRN glucose levels - see para Moderate Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is symp		idelines and notify provider.
	70-150 mg/dL - 0 units 151-200 mg/dL - 2 units subcut 201-250 mg/dL - 3 units subcut 251-300 mg/dL - 5 units subcut 301-350 mg/dL - 7 units subcut 351-400 mg/dL - 10 units subcut		
	 If blood glucose is greater than 400 mg/dL, administer 12 hours. Continue to repeat 10 units subcut and POC blood Once blood sugar is less than 300 mg/dl, repeat POC blooi insutin regular scale. □ 0-12 units, subcut, inj, q4h, PRN glucose levels - see para Moderate Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dl, and patient is symptomic sy	od sugar checks every 2 hours unt ood sugar in 4 hours and then resu ameters	il blood glucose is less than 300 mg/dL. me normal POC blood sugar checks and
If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider. 70-150 mg/dL - 0 units 151-200 mg/dL - 2 units subcut 201-250 mg/dL - 3 units subcut 251-300 mg/dL - 5 units subcut 301-350 mg/dL - 7 units subcut 351-400 mg/dL - 10 units subcut			
	If blood glucose is greater than 400 mg/dL, administer 12 hours. Continue to repeat 10 units subcut and POC bloc Once blood sugar is less than 300 mg/dl, repeat POC blo insutlin regular scale.	od sugar checks every 2 hours unt	il blood glucose is less than 300 mg/dL.
	insulin regular (High Dose Insulin Regular Sliding Scale) □ 0-14 units, subcut, inj, AC & nightly, PRN glucose levels High Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is symp	- see parameters	idelines and notify provider.
	70-150 mg/dL - 0 units 151-200 mg/dL - 3 units subcut 200-250 mg/dL - 5 units subcut 251-300 mg/dL - 7 units subcut 301-350 mg/dL - 10 units subcut 351-400 mg/dL - 12 units subcut		
¢	If blood glucose is greater than 400 mg/dL, administer 14 hours. Continue to repeat 10 units subcut and POC blood Once blood sugar is less than 300 mg/dL, repeat POC blo insulin regular sliding scale. Continued on next page	sugar checks every 2 hours until	blood glucose is less than 300 mg/dL.
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SLIDING SCALE INSULIN REGULAR PLAN

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	PI	IYSICIAN ORDERS	
	Place an "X" in the Orders column to designate orders of ch	oice AND an "x" in the spec	ific order detail box(es) where applicable.
ORDER	R ORDER DETAILS		
	0-14 units, subcut, inj, BID, PRN glucose levels - see parame High Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is sympton		idelines and notify provider.
	70-150 mg/dL - 0 units 151-200 mg/dL - 3 units subcut 200-250 mg/dL - 5 units subcut 251-300 mg/dL - 7 units subcut 301-350 mg/dL - 10 units subcut 351-400 mg/dL - 12 units subcut		
	If blood glucose is greater than 400 mg/dL, administer 14 unit hours. Continue to repeat 10 units subcut and POC blood sug Once blood sugar is less than 300 mg/dL, repeat POC blood insulin regular sliding scale. 0-14 units, subcut, inj, TID, PRN glucose levels - see parame High Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is sympton	par checks every 2 hours until sugar in 4 hours and then res ters	blood glucose is less than 300 mg/dL. ume normal POC blood sugar check and
70-150 mg/dL - 0 units 151-200 mg/dL - 3 units subcut 200-250 mg/dL - 5 units subcut 251-300 mg/dL - 7 units subcut 301-350 mg/dL - 10 units subcut 351-400 mg/dL - 12 units subcut			
	If blood glucose is greater than 400 mg/dL, administer 14 unit hours. Continue to repeat 10 units subcut and POC blood sug Once blood sugar is less than 300 mg/dL, repeat POC blood insulin regular sliding scale. 0-14 units, subcut, inj, q6h, PRN glucose levels - see parame High Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is symptom	par checks every 2 hours until sugar in 4 hours and then res ters	blood glucose is less than 300 mg/dL. ume normal POC blood sugar check and
	70-150 mg/dL - 0 units 151-200 mg/dL - 3 units subcut 200-250 mg/dL - 5 units subcut 251-300 mg/dL - 7 units subcut 301-350 mg/dL - 10 units subcut 351-400 mg/dL - 12 units subcut		
	If blood glucose is greater than 400 mg/dL, administer 14 unit hours. Continue to repeat 10 units subcut and POC blood sug Once blood sugar is less than 300 mg/dL, repeat POC blood insulin regular sliding scale. Continued on next page	ar checks every 2 hours until	blood glucose is less than 300 mg/dL.
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SLIDING SCALE INSULIN REGULAR PLAN

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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			
	 0-14 units, subcut, inj, q4h, PRN glucose levels - see parameters High Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider. 			
	70-150 mg/dL - 0 units 151-200 mg/dL - 3 units subcut 200-250 mg/dL - 5 units subcut 251-300 mg/dL - 7 units subcut 301-350 mg/dL - 10 units subcut 351-400 mg/dL - 12 units subcut			
	If blood glucose is greater than 400 mg/dL, administer 14 units subcut, notify provider, and repeat POC blood sugar check in 2 hours. Continue to repeat 10 units subcut and POC blood sugar checks every 2 hours until blood glucose is less than 300 mg/dL. Once blood sugar is less than 300 mg/dL, repeat POC blood sugar in 4 hours and then resume normal POC blood sugar check and insulin regular sliding scale.			
	insulin regular (Blank Insulin Sliding Scale) ☐ See Comments, subcut, inj, PRN glucose levels - see parameters IIf blood glucose is less thanmg/dL , initiate hypoglycemia guidelines and notify provider.			
	70-150 mg/dL units 151-200 mg/dL units subcut 201-250 mg/dL units subcut 251-300 mg/dL units subcut 301-350 mg/dL units subcut 351-400 mg/dL units subcut			
	If blood glucose is greater than 400 mg/dL, administer units subcut, notify provider, and repeat POC blood sugar check in 2 hours. Continue to repeat units subcut and POC blood sugar checks every 2 hours until blood glucose is less than 300 mg/dL. Once blood sugar is less than 300 mg/dL, repeat POC blood sugar in 4 hours and then resume normal POC blood sugar check and insulin regular sliding scale.			
	HYPOglycemia Guidelines			
	HYPOglycemia Guidelines			
	glucose ☐ 15 g, PO, gel, as needed, PRN glucose levels - see parameters If 6 ounces of juice is not an option, may use glucose gel if blood glucose is less than 70 mg/dL and patient is symptomatic and able to swallow. See hypoglycemia Guidelines. Continued on next page			
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	PHYSICIA	N ORDERS		
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	r detail box(es) where applicable.	
ORDER	ORDER DETAILS			
	 glucose (D50) 25 g, IVPush, syringe, as needed, PRN glucose levels - see parameter Use if blood glucose is less than 70 mg/dL and patient is symptomatic AND has IV access. See hypoglycemia guidelines. 	ers and cannot swallow OR if pat	ient has altered mental status	
	glucagon ☐ 1 mg, IM, inj, as needed, PRN glucose levels - see parameters Use if blood glucose is less than 70 mg/dL and patient is symptomatic AND has NO IV access. See hypoglycemia guidelines.	and cannot swallow OR if pat	ient has altered mental status	
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	Physician Signature: Time			
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UMC Health System		Patient Label Here		
VTE PROPHYLAXIS PLAN				
	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				
	Patient Care VTE Guidelines			
	See Reference Text for Guidelines			
	If VTE Pharmacologic Prophylaxis not given, choose the Contraindications for VTE below and complete reason contraindi cated			
	Contraindications VTE			
	Active/high risk for bleeding Patient or caregiver refused	 Treatment not indicated Other anticoagulant order 	ed	
	Anticipated procedure within 24 hours	Intolerance to all VTE che		
	Apply Elastic Stockings	_		
	Apply to: Bilateral Lower Extremities, Length: Knee High Apply to: Right Lower Extremity (RLE), Length: Knee High		mity (LLE), Length: Knee High Extremities, Length: Thigh High	
	Apply to: Right Lower Extremity (RLE), Length: Right High		remity (RLE), Length: Thigh High	
	Apply Sequential Compression Device	_		
	Apply to Bilateral Lower Extremities Apply to Right Lower Extremity (RLE)	Apply to Left Lower Extrem	mity (LLE)	
	Medications			
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.			
	 VTE Prophylaxis: Trauma Dosing. For CrCl LESS than 30 mL/min, use heparin. Pharmacy will adjust enoxaparin dose based on body weight. enoxaparin (enoxaparin for weight 40 kg or GREATER) 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			
	heparin ☐ 5,000 units, subcut, inj, q12h	☐ 5,000 units, subcut, inj, q8	3h	
	VTE Prophylaxis: Non-Trauma Dosing			
	 enoxaparin (enoxaparin for weight 40 kg or GREATER) 40 mg, subcut, syringe, q24h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function 30 mg, subcut, syringe, q12h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function 30 mg, subcut, syringe, q24h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function 40 mg, subcut, syringe, q12h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function per Renal Function 			
	rivaroxaban 10 mg, PO, tab, In PM			
	warfarin 5 mg, PO, tab, In PM			
	aspirin 325 mg, PO, tab, Daily 81 mg, PO, tab chew, Daily 325 mg, PO, tab, Daily Fondaparinux may only be used in adults 50 kg or GREATER. Prophylactic use is contraindicated in patients LESS than 50 kg or CrCI LESS than 30 mL/min fondaparinux 2.5 mg, subcut, syringe, q24h Prophylactic use is contraindicated in patients LESS than 50 kg or CrCI LESS than 30 mL/min			
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Order Take	en by Signature:	Date	Time	
Physician Signature: Date			Time	