UMC Health System

CARDIO POST EP IMPLANTABLE DEVICE PLAN

Patient Label Here

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
	Condition/Status
	If this patient is an OUTPATIENT, you MUST place the Code Status order below: **Code Status**
	Patient Care
	Activity Precautions ☐ Instruct patient to not raise elbow on implant side above shoulder level for 4 weeks.
	Vital Signs ☐ Per Unit Standards, Vital signs every 15 minutes x4 then every 30 minutes x2, then per unit standards
	Wound Care by Nursing ☐ Cover/Pack with Other, Located: Device Implant site, Change PRN, Keep dressing in place for 2 days. Do NOT Remove Steri-Strips.
	Convert IV to INT ☐ When tolerating diet
	Patient Activity ☐ Bedrest, for 2 hours then activity as tolerated. ☐ Bedrest, until AM then activity as tolerated.
	Communication
	Instruct Patient ☐ Instruct Patient On: Other, Provide printed post implant instructions to patient. Review these instructions with the patient
	.Medication Management ☐ BID, NOW, Start date T;N No enoxaparin or heparin until authorized by cardiology.
	Notify Nurse (DO NOT USE FOR MEDS) ☐ Notify pacemaker rep at 0800 next day
	Notify Provider (Misc) ☐ Reason: If Hematoma develops or for needed dressing change.
	Notify Nurse (DO NOT USE FOR MEDS) ☐ If patient has Dermabond dressing may shower 8 hours post incision.
	Dietary

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

CARDIO POST EP IMPLANTABLE DEVICE PLAN

Patient Label Here

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
	Oral Diet ☐ Heart Healthy Diet ☐ Clear Liquid Diet ☐ Full Liquid Diet ☐ Regular Diet ☐ Clear Liquid Diet, Advance as tolerated to Regular ☐ Clear Liquid Diet Diet, Advance as tolerated to Heart Healthy ☐ Clear Liquid Diet Diet, Advance as tolerated to Carbohydrate Controlled (1600 calories) ☐ Clear Liquid Diet Diet, Advance as tolerated to Carbohydrate Controlled (2000 calories) ☐ Carbohydrate Controlled (1600 calories) | Heart Healthy Diet ☐ Carbohydrate Controlled (2000 calories) | Heart Healthy Diet
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	ceFAZolin ☐ 1 g, IVPush, inj, q8h, x 3 dose, Pre-OP/Post-Op Prophylaxis Begin 8 hours after Pre-Op/Intra-Op dose. Reconstitute with 10 mL of Sterile Water or NS. Administer IV Push over 3 minutes.
	If allergic to penicillins or cephalosporins give vancomycin **vancomycin** ☐ 1,000 mg, IVPB, ivpb, q12h, x 1 dose, Infuse over 90 min, Pre-OP/Post-Op Prophylaxis Give 12 hours after Pre-Op/Intra-Op dose.
	Laboratory
	Click to review cardiac labs
	Basic Metabolic Panel (BMP) ☐ STAT
	CBC ☐ STAT
	Comprehensive Metabolic Panel ☐ STAT
	Hemoglobin and Hematocrit ☐ STAT
	Hemoglobin and Hematocrit ☐ STAT, q3h 3 times
	Magnesium Level ☐ STAT
	Prothrombin Time with INR ☐ STAT
	PTT ☐ STAT
	D Dimer HS 500 ☐ STAT
	Hemoglobin A1C ☐ Next Day in AM, T+1;0300, for 1 days

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System CARDIO POST EP IMPLANTABLE DEVICE PLAN	Patient Label Here

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**
	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 ☐ Next Day in AM, T+1;0300, for 3 days
	Magnesium Level ☐ Next Day in AM, T+1;0300, for 3 days
	Anti Xa Level
	POC Blood Sugar Check
	Diagnostic Tests
	Notify Nurse (DO NOT USE FOR MEDS) ☐ EKG STAT PRN Chest Pain
	DX Chest PA & Lateral ☐ T+1;0500, Routine, Rule out delayed pneumothorax and lead positioning.
	DX Chest Portable ☐ STAT, Post PPM insertion to rule out pneumothorax. Perform immediately upon patient arrival to room.
	EKG-12 Lead ☐ Routine, Abnormal ECG
	EKG-12 Lead ☐ Routine, Abnormal ECG, Every AM for 2 days
	Echo Transthoracic (TTE) with contrast i (Echo Transthoracic (TTE) with contrast if needed) ☐ Pericardial Effusion
	Limited Echo Transthoracic (Limited TTE) ☐ Pericardial Effusion
	VL LE Arterial/BG Bilat (Vascular Lab) ☐ Routine, Post procedure/Post stent follow up
	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

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System CARDIO POST EP IMPLANTABLE DEVICE PLAN	Patient Label Here

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.

	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. Arrange Outpatient Cardiac Rehab Phase II evaluation and treatment.
	...Additional Orders

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System BB TYPE AND SCREEN PLAN	Patient Label Here

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
	Laboratory
	BB Blood Type (ABO/Rh)
	BB Antibody Screen

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

DISCOMFORT MED PLAN

Patient Label Here

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
	Patient Care
	Perform Bladder Scan ☐ 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.
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	menthol-benzocaine topical (Chloraseptic 6 mg-10 mg mucous membrane lozenge) ☐ 1 lozenge, mucous membrane, lozenge, q4h, PRN sore throat
	dextromethorphan-guaiFENesin (dextromethorphan-guaiFENesin 20 mg-200 mg/10 mL oral liquid) ☐ 10 mL, PO, liq, q4h, PRN cough
	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

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

DISCOMFORT MED PLAN

Patient Label Here

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
	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*** ☐ 2 tab, PO, tab, q4h, PRN pain-moderate (scale 4-6) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***
	acetaminophen-codeine (acetaminophen-codeine (Tylenol with Codeine) 300 mg-30 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*** ☐ 2 tab, PO, tab, q4h, PRN pain-moderate (scale 4-6) ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***
	traMADol ☐ 50 mg, PO, tab, q6h, PRN pain-moderate (scale 4-6) ☐ 50 mg, PO, tab, q4h, PRN pain-moderate (scale 4-6)
	ketorolac ☐ 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, q4h, PRN pain-severe (scale 7-10)
	HYDROmorphone ☐ 0.2 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 7-10) ☐ 0.4 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 7-10) ☐ 0.6 mg, Slow IVPush, inj, q4h, 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-magnesium hydroxide-simethicone 200 mg-200 mg-20 mg/5 mL oral suspension) ☐ 30 mL, PO, susp, q4h, PRN indigestion Administer 1 hour before meals and nightly.

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

DISCOMFORT MED PLAN

Patient Label Here

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
	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%-0.25% rectal ointment) ☐ 1 app, rectally, oint, q6h, PRN hemorrhoid care Apply to affected area

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

ELECTROLYTE MED PLAN - ICU ONLY

Patient Label Here

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
	Communication
	ICU Only - Adult Electrolyte Replacement (ICU Only - Adult Electrolyte Replacement Guidelines) ☐ T;N, See Reference Sheet
	Check below to select the Aggressive Potassium, phosphate, and magnesium. May then uncheck any replacement orders not wanted. **Communication Order** ☐ T;N
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	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: **potassium chloride** ☐ 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.
	potassium chloride ☐ 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.
	potassium chloride ☐ 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....

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

ELECTROLYTE MED PLAN - ICU ONLY

Patient Label Here

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
	NON-AGGRESSIVE IV POTASSIUM REPLACEMENT - Replacement doses for potassium levels LESS than or equal to 3.5 mMol/L: **potassium chloride** ☐ 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.
	potassium chloride ☐ 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.
	IV SODIUM PHOSPHATE REPLACEMENT: Use only when phosphorous needs replacement Select only ONE of the following sodium phosphate replacement orders - Aggressive or Non-Aggressive 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. **sodium phosphate** ☐ 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. Repeat serum phosphorus level 6 hours after infusion completed.
	sodium phosphate ☐ 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. Repeat serum phosphate level 6 hours after infusion completed.
	NON-AGGRESSIVE IV SODIUM PHOSPHATE REPLACEMENT: Select both sodium phosphate orders to replace phos levels LESS than or equal to 2.5 mg/dL **sodium phosphate** ☐ 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. Repeat serum phosphorus level 6 hours after infusion completed. Continued on next page....

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System ELECTROLYTE MED PLAN - ICU ONLY	Patient Label Here

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
	sodium phosphate ☐ 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. 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 serum magnesium levels 1.6 - 1.9 mg/dL. 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 completed.
	magnesium sulfate ☐ 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. Administer at rate of 1 g/hr, and repeat serum magnesium level 2 hours after the infusion is completed.
	IV POTASSIUM PHOSPHATE REPLACEMENT: 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 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 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.
	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. **Notify Provider (Misc) (Notify Provider of Results)** ☐ 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.
	Laboratory
	Potassium Level
	Phosphorus Level
	Magnesium Level
	Sodium Level

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

GERIATRIC DISCOMFORT MED PLAN

Patient Label Here

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
	Patient Care
	Perform Bladder Scan ☐ 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.
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	menthol-benzocaine topical (Chloraseptic 6 mg-10 mg mucous membrane lozenge) ☐ 1 lozenge, mucous membrane, lozenge, q4h, PRN sore throat
	dextromethorphan-guaiFENesin (dextromethorphan-guaiFENesin 20 mg-200 mg/10 mL oral liquid) ☐ 10 mL, PO, liq, q4h, PRN cough
	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 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 **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 ****
	acetaminophen-codeine (acetaminophen-codeine (Tylenol with Codeine) 300 mg-30 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*****
	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

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

GERIATRIC DISCOMFORT MED PLAN

Patient Label Here

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
	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-magnesium hydroxide-simethicone 200 mg-200 mg-20 mg/5 mL oral suspension) ☐ 30 mL, PO, susp, q4h, PRN indigestion Administer 1 hour before meals and nightly.
	simethicone ☐ 80 mg, PO, tab chew, q4h, PRN gas ☐ 160 mg, PO, tab chew, q4h, PRN gas
	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) ☐ 1 app, rectally, oint, q6h, PRN hemorrhoid care Apply to affected area

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

HEPARIN INFUSION MED PLAN

Patient Label Here

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
	Patient Care
	Heparin Infusion Nomogram ☐ ***See Reference Text***
	Check the .Medication Management order below if the patient requires specific monitoring and heparin adjustments per provider. AntiXa levels must be used. aPTT levels will not be accepted for monitoring and heparin adjustments. **.Medication Management (Notify Nurse and Pharmacy)** ☐ BID, Start date T;N DO NOT USE NOMOGRAM - Patient requires specific monitoring and heparin adjustments per provider. AntiXa levels must be used. aPTT levels will not be accepted for monitoring and heparin adjustments.
	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.
	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 below 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 total daily dose if needed.
	.Medication Management ☐ Start date T;N Discontinue all other orders for heparin products (i.e. heparin sububcutaneous, 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 mL D5W (Venous Thromboembolic)) ☐ IV Indication: DVT/PE. The initial maximum rate is 18 units/kg/hr not to exceed a total hourly dose of 1,800 units. Final concentrati on = 100 unit/mL. Refer to Heparin Infusion Nomogram for maintenance dose adjustments or contact provider if patient requires specific adjustments. Continued on next page....

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

HEPARIN INFUSION MED PLAN

Patient Label Here

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
	☐ 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: unstable angina, STEMI or non-STEMI. Recommended maximum dose is 4,000 units.
	heparin 25,000 units/250 mL D5W (Cardiac (heparin 25,000 units/250 mL D5W (Cardiac)) ☐ Start at rate:_____units/kg/hr ☐ IV
	Neurological
	Ischemic strokes with a suspected embolic source in which thrombolytics have NOT been given and a CT has confirmed NO cerebral hemorrhage No initial heparin load dose recommended. **heparin 25,000 units/250 mL D5W (Neurolo (heparin 25,000 units/250 mL D5W (Neurological))** ☐ IV Indication: Ischemic Stroke. Initial maximum rate is 12 units/kg/hr not to exceed a total hourly dose of 1,200 units. Final concentration = 100 unit/mL. Refer to Heparin Infusion Nomogram for maintenance dose adjustments or contact provider if patient requires specific adjustments. ☐ Start at rate:_____units/kg/hr
	Laboratory
	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

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

PAIN MANAGEMENT - ALTERNATING SCHEDULED MEDS

Patient Label Here

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
	Medications
	Medication sentences are per dose. You will need to calculate a total 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 mg of acetaminophen per day from all sources.
	For renally impared patients: The following scheduled orders will alternate 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 mg of acetaminophen per day from all sources.

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

POTASSIUM CHLORIDE REPLACEMENT PLAN

Patient Label Here

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
	Patient Care
	Potassium Replacement Guidelines ☐ T;N, See Reference Text
	Medications
	Medication sentences are per dose. You will need to calculate a total 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 ORAL supplementation. If contraindicated, give IV potassium replacement if ordered. If K+ level less than 3.1 mMol/L -Contact provider immediately as IV replacement may be necessary. If K+ level 3.1 - 3.5 mMol/L - Administer 40 mEq KCl oral. May give each 20 mEq tablets two hours apart to prevent GI discomfort 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, 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. Repeat serum potassium level 2 hours after total replacement is completed.
	potassium chloride ☐ 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. Repeat serum potassium level 2 hours after total replacement is completed.

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

SLIDING SCALE INSULIN REGULAR PLAN

Patient Label Here

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
	Patient Care
	POC Blood Sugar Check ☐ Per Sliding Scale Insulin Frequency ☐ AC & HS 3 days ☐ BID ☐ q6h ☐ q4h ☐ AC & HS ☐ TID ☐ q12h ☐ q6h 24 hr
	Sliding Scale Insulin Regular Guidelines ☐ Follow SSI Regular Reference Text
	Medications **Medication sentences are per dose. You will need to calculate a total daily dose if needed.**
	insulin regular (Low Dose Insulin Regular Sliding Scale) ☐ 0-10 units, subcut, inj, AC & nightly, 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 - 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. ☐ 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, initiate 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. Continued on next page....

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

SLIDING SCALE INSULIN REGULAR PLAN

Patient Label Here

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
	☐ 0-10 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 - 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. ☐ 0-10 units, subcut, inj, q6h, 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 - 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. ☐ 0-10 units, subcut, inj, q4h, 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 - 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. Continued on next page....

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

SLIDING SCALE INSULIN REGULAR PLAN

Patient Label Here

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
	insulin regular (Moderate Dose Insulin Regular Sliding Scale) ☐ 0-12 units, subcut, inj, AC & nightly, 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. ☐ 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, 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. ☐ 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....

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

SLIDING SCALE INSULIN REGULAR PLAN

Patient Label Here

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
	☐ 0-12 units, subcut, inj, q6h, 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. ☐ 0-12 units, subcut, inj, q4h, 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.
	insulin regular (High Dose Insulin Regular Sliding Scale) ☐ 0-14 units, subcut, inj, AC & nightly, 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. Continued on next page....

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

SLIDING SCALE INSULIN REGULAR PLAN

Patient Label Here

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, BID, 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. ☐ 0-14 units, subcut, inj, TID, 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. ☐ 0-14 units, subcut, inj, q6h, 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. Continued on next page....

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

SLIDING SCALE INSULIN REGULAR PLAN

Patient Label Here

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 than ____mg/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 ☐ ***See Reference Text***
	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....

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

SLIDING SCALE INSULIN REGULAR PLAN

Patient Label Here

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
	glucose (D50) ☐ 25 g, IVPush, syringe, as needed, PRN glucose levels - see parameters Use if blood glucose is less than 70 mg/dL and patient is symptomatic and cannot swallow OR if patient has altered mental status AND has IV access. See hypoglycemia guidelines.
	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 cannot swallow OR if patient has altered mental status AND has NO IV access. See hypoglycemia guidelines.

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____

UMC Health System

VTE PROPHYLAXIS PLAN

Patient Label Here

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
	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 ☐ Anticipated procedure within 24 hours ☐ Treatment not indicated ☐ Other anticoagulant ordered ☐ Intolerance to all VTE chemoprophylaxis
	Apply Elastic Stockings ☐ Apply to: Bilateral Lower Extremities, Length: Knee High ☐ Apply to: Right Lower Extremity (RLE), Length: Knee High ☐ Apply to: Left Lower Extremity (LLE), Length: Thigh High ☐ Apply to: Left Lower Extremity (LLE), Length: Knee High ☐ Apply to: Bilateral Lower Extremities, Length: Thigh High ☐ Apply to: Right Lower Extremity (RLE), Length: Thigh High
	Apply Sequential Compression Device ☐ Apply to Bilateral Lower Extremities ☐ Apply to Right Lower Extremity (RLE) ☐ Apply to Left Lower Extremity (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, q8h
	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, for BMI Greater than or Equal to 40 kg/m2, Pharmacy to Adjust Dose per Renal Function
	rivaroxaban ☐ 10 mg, PO, tab, In PM
	warfarin ☐ 5 mg, PO, tab, In PM
	aspirin ☐ 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 CrCl LESS than 30 mL/min **fondaparinux** ☐ 2.5 mg, subcut, syringe, q24h Prophylactic use is contraindicated in patients LESS than 50 kg or CrCl LESS than 30 mL/min

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ **Date** _____ **Time** _____