UMC Health System

CONTINUE INSULIN PUMP

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
	Communication
	Continue Personal Insulin Infusion Pump
	Notify Provider (Misc) ☐ T;N, Reason: For 2 sequential blood glucose checks greater than or equal to 300 mg/dL
	Notify Provider (Misc) ☐ T;N, Reason: For personal insulin pump off for greater than or equal to 2 hours or for no insulin in pump.
	Notify Nurse (DO NOT USE FOR MEDS) ☐ T;N, Contact Diabetic Educator via CareAware
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	Self Administered Scheduled Orders Choose Insulin that matches the patient's pump: **insulin aspart (insulin aspart ***For Insulin Pump***)** ☐ For Insulin Pump - as directed at home, subcut, inj, AC & nightly Document patient reported self insulin pump administration
	insulin glulisine (insulin glulisine ***For Insulin Pump*)** ☐ For Insulin Pump - as directed at home, subcut, soln, AC & nightly **Patient's Own Med** Pharmacy does not stock. Bring med to pharmacy for labeling when available. Document patient reported self insulin pump administration
	insulin lispro (insulin lispro ***For Insulin Pump*)** ☐ For Insulin Pump - as directed at home, subcut, inj, AC & nightly **Patient's Own Med** Pharmacy does not stock. Bring med to pharmacy for labeling when available. Document patient reported self insulin pump administration
	insulin regular (insulin regular ***For Insulin Pump*)** ☐ For Insulin Pump - as directed at home, subcut, inj, AC & nightly Document patient reported self insulin pump administration
	Concentrated Insulin Orders **insulin lispro (insulin lispro U-200 ***For Insulin Pump***)** ☐ U200 For InsulinPump-as directed at home, subcut, soln, AC & nightly **Patient's Own Med** Pharmacy does not stock. Bring med to pharmacy for labeling when available. Document patient reported self insulin pump administration Continued on next page....

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Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System CONTINUE INSULIN PUMP	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 (insulin regular concentrated U-500 ***For Insulin Pump*)** ☐ U500 For InsulinPump-as directed at home, subcut, soln, AC & nightly **Patient's Own Med** Pharmacy does not stock. Bring med to pharmacy for labeling when available. Document patient reported self insulin pump administration
	. Self Administered PRN Bolus Orders * An order will automatically select based on Scheduled Order chosen above* **insulin aspart (insulin aspart ***For Insulin Pump***)** ☐ For Insulin Pump - as directed at home, subcut, inj, as needed, PRN per pump parameters Document patient reported self insulin pump administration
	insulin glulisine (insulin glulisine ***For Insulin Pump*)** ☐ For Insulin Pump - as directed at home, subcut, soln, as needed, PRN per pump parameters **Patient's Own Med** Pharmacy does not stock. Bring med to pharmacy for labeling when available. Document patient reported self insulin pump administration
	insulin lispro (insulin lispro ***For Insulin Pump*)** ☐ For Insulin Pump - as directed at home, subcut, inj, as needed, PRN per pump parameters Document patient reported self insulin pump administration
	insulin regular (insulin regular ***For Insulin Pump*)** ☐ For Insulin Pump - as directed at home, subcut, inj, as needed, PRN per pump parameters **Patient's Own Med** Document patient reported self insulin pump administration
	Concentrated Insulin Orders **insulin lispro (insulin lispro U-200 ***For Insulin Pump***)** ☐ U200 For InsulinPump-as directed at home, subcut, soln, as needed, PRN per pump parameters **Patient's Own Med** Pharmacy does not stock. Bring med to pharmacy for labeling when available. Document patient reported self insulin pump administration
	insulin regular (insulin regular concentrated U-500 ***For Insulin Pump*)** ☐ U500 For InsulinPump-as directed at home, subcut, soln, as needed, PRN per pump parameters **Patient's Own Med** Pharmacy does not stock. Bring med to pharmacy for labeling when available. Document patient reported self insulin pump administration
	Consults/Referrals
	Consult MD ☐ Service: Endocrinology, Reason: Personal insulin pump

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Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System

HYPOGLYCEMIA GUIDELINES 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
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	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.
	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.

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Order Taken by Signature: _____ Date _____ Time _____

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