UMC Health System ECMO POST CANNULATION 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**
	Patient Care
	Change attending physician to (Lachmansingh/Phillps) and Transfer patient to CVICU ***DO NOT accept/carry out new orders without approval of CV surgery or ICU CVICU intensivist*** ***Place patient in non violent restraints (bilateral upper extremities) if not medically paralyzed*** **Restraint Assessment - Non-Violent** ☐ T;N
	Maintain Gastric Tube ☐ T;N
	Maintain Urinary Catheter (Maintain Foley) ☐ T;N, Routine, Accuryn Foley Catheter
	Communication
	Notify Nurse (DO NOT USE FOR MEDS) ☐ T;N, Maintain sweep gas to attain a pCO2 of 35-45 off of ABGs
	Notify Nurse (DO NOT USE FOR MEDS) ☐ T;N, Platelets to remain greater than 100/KuL and Hemoglobin greater than 8.5 G/DL
	Notify Nurse (DO NOT USE FOR MEDS) ☐ T;N, All flow changes should be cleared by CVICU/Neuro Intensivists or Cannulating CV surgeon.
	Notify Nurse (DO NOT USE FOR MEDS) ☐ T;N, Obtain Anti-Xa level every 4 hours for the duration of heparin infusion and patient on ECMO.
	Notify Provider (Misc) ☐ T;N, Reason: If platelet count decreases by 50% of baseline or falls below 100,000/uL.
	Notify Provider (Misc) ☐ T;N, Reason: If Hemoglobin decreases by 2g/dL
	Notify Provider (Misc) ☐ T;N, Reason: If signs of bleeding occur
	Notify Provider (Misc) ☐ T;N, Reason: For blood glucose GREATER than 300 for Greater than 24 hours.
	IV Solutions
	ECMO Heparin Infusion Nomogram ☐ T;N, ***See Reference Text***
	.Medication Management

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ECMO POST CANNULATION 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**
	☐ ONE TIME, Start date T;N Patient on ECMO and requires specific monitoring and heparin adjustments per provider. AntiXa levels must be drawn every 4 hours for the duration of heparin infusion while patient on ECMO. Discontinue all other orders for heparin products (i.e. heparin subcutaneous, enoxaparin).
	heparin 25,000 units/250 mL 1/2 NS ☐ IV ECMO Heparin Infusion: Provider order required for all rate adjustments. ☐ Start at rate:_____units/kg/hr ECMO Heparin Infusion: Provider order required for all rate adjustments.
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	aspirin ☐ 325 mg, PO, tab, Daily IF NPO, contact provider to obtain order to change to suppository ☐ 300 mg, rectally, supp, Daily IF patient able to take PO, contact provider to change to oral tablet
	NS (NS bolus) ☐ 1,000 mL, IVPB, iv soln, q1h, hypovolemia, Infuse over 1 hr
	LR (LR bolus) ☐ 1,000 mL, IVPB, iv soln, q1h, hypovolemia, Infuse over 1 hr
	Laboratory
	CBC with Differential ☐ STAT, T;N, q4h
	CK ☐ STAT, T;N, q4h
	Comprehensive Metabolic Panel ☐ STAT, T;N, q4h
	Fibrinogen Level ☐ Next Day in AM, T+1;0300, Every AM
	Hepatic Function Panel (Liver Function Panel) ☐ STAT, T;N, Every AM
	Magnesium Level ☐ STAT, T;N, q4h
	Phosphorus Level ☐ STAT, T;N, q4h
	PTT ☐ STAT, T;N, q4h
	Brain Natriuretic Peptide (proBNP) (PROBNP) ☐ STAT, T;N, Every AM

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Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ECMO POST CANNULATION 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**
	Prothrombin Time with INR ☐ STAT, T;N, q4h
	Anti Xa Level ☐ STAT, T;N, q4h
	---Type and Screen--- **BB Blood Type (ABO/Rh)** ☐ STAT, T;N
	BB Antibody Screen ☐ STAT, T;N
	BB Clot to Hold ☐ STAT, T;N
	Diagnostic Tests
	DX Chest Portable (CXR Portable) ☐ T;N, STAT, Every AM
	Respiratory
	EMERGENCY: In the event of ECMO failure, change ventilator settings to Peep 20, Pressure Control 16, Respiratory Rate 10. CONTACT PROVIDER and PERFUSION IMMEDIATLEY ***Alert MD or Perfusion if Delta-p>40mmhg ((delta p) pressure change is greater than)*** **Arterial Blood Gas (ABG)** ☐ STAT, Every AM, Pre and Post Oxygenator
	Arterial Blood Gas (ABG) ☐ STAT, Additional Tests: Lactate, q2h, q2h until no changes on ECMO for 2 consecutive ABGS, q4h after.
	Arterial Blood Gas (ABG) ☐ STAT, Additional Tests: Lactate, 30 minutes after change on ECMO
	Ventilator Settings ☐ Mode: PC, 10 bpm, 40 %O2, PEEP/CPAP/EPAP (cmH2O): 10, Keep sats greater than %: 88, ASV% Minute Volume 10
	Notify RT ☐ All ventilator adjustments are to be cleared through CVICU/Neuro Intensivists or Cannulating CV surgeon
	Consults/Referrals
	Consult Dietitian for Tube Feeding ☐ T;N, RD to Manage ☐ T;N, RD for Recommendations Only
	Social Services for Assessment and Eval (Discharge Planning Evaluation by Social Services) ☐ T;N
	...Additional Orders

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Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System CARDIAC MED INFUSION 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.
	Antiarrhythmics
	amiodarone 900 mg/500 mL D5W ☐ IV, See order comments Start at 1 mg/min IV x 6 hours (33 mL/hr) then decrease to 0.5 mg/min IV x 18 hours (17 mL/hr) ☐ 900 mg, Every Bag
	Fixed Rate: **dilTIAZem 125 mg/125 mL NS - Fixed Rate** ☐ IV, See order Comments Final concentration = 1 mg/mL. Provider order REQUIRED for ALL rate changes. ☐ Start at rate:_____mg/hr
	Antihypertensives
	Titratable: **niCARdipine 25 mg/250 mL - Titratable** ☐ IV, Maximum titration: 2.5 Titration units: mg/hr every every 5 minutes, Max dose: 15 mg/hr ☐ Start at rate:_____mg/hr
	Fixed Rate: **niCARdipine 25 mg/250 mL NS - Fixed Rate** ☐ IV ☐ Start at rate:_____mg/hr
	Vasodilators
	Titratable: **milrinone 20 mg/100 mL D5W - Titratable** ☐ IV, Max dose: 1 mcg/kg/min Final concentration = 0.2 mg/mL (200 mcg/mL). ☐ Start at rate:_____mcg/kg/min
	nitroGLYCerin 50 mg/250 mL D5W - Titrata (nitroGLYCerin 50 mg/250 mL D5W - Titratable) ☐ IV, Max dose: 200 mcg/min Final concentration = 0.2 mg/mL (200 mcg/mL). ☐ Start at rate:_____mcg/min
	nitroPRUSSIDE 50 mg/250 mL D5W - Titrata (nitroPRUSSIDE 50 mg/250 mL D5W - Titratable) ☐ IV, Max dose: 10 mcg/kg/min ☐ Start at rate:_____mcg/kg/min
	Fixed Rate: **milrinone 20 mg/100 mL D5W - Fixed Rate** ☐ IV, See order comments Final concentration = 0.2 mg/mL (200 mcg/mL). Provider order REQUIRED for ALL rate changes. ☐ Start at rate:_____mcg/kg/min
	nitroGLYCerin 50 mg/250 mL D5W - Fixed R (nitroGLYCerin 50 mg/250 mL D5W - Fixed Rate) ☐ IV, See order comments Final concentration = 0.2 mg/mL (200 mcg/mL). Provider order REQUIRED for ALL rate changes. ☐ Start at rate:_____mcg/min

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Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System CARDIAC MED INFUSION 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**
	nitroPRUSSIDE 50 mg/250 mL D5W - Fixed R (nitroPRUSSIDE 50 mg/250 mL D5W - Fixed Rate) ☐ Start at rate:_____mcg/kg/min ☐ IV, See order comments
	Inotropes
	Titratable: **DOBUTamine 250 mg/250 mL D5W - Titratabl (DOBUTamine 250 mg/250 mL D5W - Titratable)** ☐ IV, Max dose: 50 mcg/kg/min Final concentration = 1 mg/mL (1,000 mcg/mL). ☐ Start at rate:_____mcg/kg/min
	DOPamine 400 mg/250 mL D5W - Titratable ☐ IV, Max dose: 50 mcg/kg/min Final concentration= 1.6 mg/mL (1,600 mcg/mL). ☐ Start at rate:_____mcg/kg/min
	EPINEPHrine 4 mg/250 mL NS - Titratable ☐ IV, Max dose: 20 mcg/min Final concentration = 0.016 mg/mL (16 mcg/mL). ☐ Start at rate:_____mcg/min
	norepinephrine 4 mg/250 mL NS - Titratab (norepinephrine 4 mg/250 mL NS - Titratable) ☐ IV, Max dose: 60 mcg/min Final concentration = 0.016 mg/mL (16 mcg/mL). ☐ Start at rate:_____mcg/min
	phenylephrine 10 mg/250 mL NS - Titratab (phenylephrine 10 mg/250 mL NS - Titratable) ☐ IV, Max dose: 180 mcg/min Final concentration = 0.04 mg/mL (40 mcg/mL). ☐ Start at rate:_____mcg/min
	Fixed Rate: **DOBUTamine 250 mg/250 mL D5W - Fixed Rat (DOBUTamine 250 mg/250 mL D5W - Fixed Rate)** ☐ IV, See order comments Final concentration = 1 mg/mL (1,000 mcg/mL). Provider order REQUIRED for ALL rate changes. ☐ Start at rate:_____mcg/kg/min
	DOPamine 400 mg/250 mL D5W - Fixed Rate ☐ IV, See order comments Final concentration = 1.6 mg/mL (1600 mcg/mL). Provider order REQUIRED for ALL rate changes. ☐ Start at rate:_____mcg/kg/min
	EPINEPHrine 4 mg/250 mL NS - Fixed Rate ☐ IV, See order comments Final concentration = 0.016 mg/mL (16 mcg/mL). Provider order REQUIRED for ALL rate changes. ☐ Start at rate:_____mcg/min
	norepinephrine 4 mg/250 mL NS - Fixed Ra (norepinephrine 4 mg/250 mL NS - Fixed Rate) ☐ IV, See order comments Final concentration = 0.016 mg/mL (16 mcg/mL). Provider order REQUIRED for ALL rate changes. ☐ Start at rate:_____mcg/min

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Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System CARDIAC MED INFUSION 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**
	phenylephrine 10 mg/250 mL NS - Fixed Ra (phenylephrine 10 mg/250 mL NS - Fixed Rate) ☐ IV, See order comments Final concentration = 0.04 mg/mL (40 mcg/mL). Provider order REQUIRED for ALL rate changes. ☐ Start at rate:_____mcg/min

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Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ICU SEDATION AND PAIN 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
	Utilize the Richmond Agitation Sedation (Utilize the Richmond Agitation Sedation Scale) ☐ ***See Reference Text***
	Perform Awakening Trial ☐ Daily ***See Reference Text***
	ICU Pain/Agitation/Delirium Reference ☐ ***See Reference Text***
	Brain Function Monitoring ☐ 2 to 4 Channel EEG.
	Communication
	Notify Nurse (DO NOT USE FOR MEDS) ☐ Assess patient's sedation and pain level every 4 hours.
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	SEDATIVE MEDICATIONS SHOULD ONLY BE GIVEN AFTER PAIN IS ADEQUATELY CONTROLLED If delirium noted give: **haloperidol** ☐ 5 mg, IVPush, inj, q2h, PRN agitation Notify physician if more than 100 mg is administered over 48 hours.
	Initial Dose
	Pain Meds **morphine** ☐ 2 mg, IVPush, inj, q10min, PRN pain-with sedation (scale 4-10) Administer until pain level is less than 4/10.
	fentaNYL ☐ 50 mcg, IVPush, inj, q10min, PRN pain-with sedation (scale 4-10) Administer until pain level is less than 4/10.
	HYDROmorphone ☐ 0.25 mg, IVPush, inj, q5min, PRN pain-with sedation (scale 4-10) Administer until pain level is less than 4/10.
	Sedation Meds **propofol** ☐ 25 mg, IVPush, inj, ONE TIME
	midazolam ☐ 2 mg, IVPush, inj, q20min, PRN sedation ***Sedative medications should only be given after pain is adequately controlled***
	LORazepam ☐ 2 mg, IVPush, inj, q20min, PRN sedation ***Sedative medications should only be given after pain is adequately controlled***

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System

ICU SEDATION AND PAIN 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
	ketamine ☐ 4 mg/kg, IVPush, inj, ONE TIME Infuse slowly with inotropes amiodarone or milrinone or patients that are hypertensive with a blood pressure GREATER than 180/90. ☐ 5 mg/kg, IVPush, inj, ONE TIME Infuse slowly with inotropes amiodarone or milrinone or patients that are hypertensive with a blood pressure GREATER than 180/90. ☐ 6 mg/kg, IVPush, inj, ONE TIME Infuse slowly with inotropes amiodarone or milrinone or patients that are hypertensive with a blood pressure GREATER than 180/90.
	Intermittent Dose
	Pain Meds **morphine** ☐ 2 mg, IVPush, inj, q2h, PRN pain-with sedation (scale 4-10) To maintain pain level less than 4/10. May increase 1 mg every 2 hours to a maximum of 4 mg. ☐ 4 mg, IVPush, inj, q2h, PRN pain-with sedation (scale 4-10) To maintain pain level less than 4/10.
	fentaNYL ☐ 50 mcg, IVPush, inj, q2h, PRN pain-with sedation (scale 4-10) Administer to maintain pain level less than 4/10.
	HYDROmorphone ☐ 1 mg, IVPush, inj, q4h, PRN pain-with sedation (scale 4-10) To maintain pain level less than 4/10.
	Sedation Meds **midazolam** ☐ 2 mg, IVPush, inj, q1h, PRN sedation ***Sedative medications should only be given after pain is adequately controlled***
	LORazepam ☐ 2 mg, IVPush, inj, q2h, PRN sedation ***Sedative medications should only be given after pain is adequately controlled***
	Continuous Infusion
	Pain Meds **morphine 100 mg/100 mL NS - Titratable** ☐ Start at rate:_____mg/hr ☐ IV, Max titration: 1 mg/hr every 30 minutes, Max dose: 8 mg/hr Final concentration = 1 mg/mL. ***Do NOT initiate infusion unless intermittent dosing has failed*** Continued on next page....

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ICU SEDATION AND PAIN 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
	fentaNYL 1000 mcg/100 mL NS - Titratable ☐ Start at rate:_____mcg/hr ☐ IV, Max titration: 25 mcg/hr every 10 minutes, Max dose: 250 mcg/hr Final concentration = 10 mcg/mL. ***Do NOT initiate infusion unless intermittent dosing has failed***
	HYDROmorphone 20 mg/100 mL NS - Titratab (HYDROmorphone 20 mg/100 mL NS - Titratable) ☐ Start at rate:_____mg/hr ☐ IV, Max titration: 0.2 mg/hr every 30 minutes, Max dose: 3 mg/hr Final concentration = 0.2 mg/mL (200 mcg/mL). ***Do NOT initiate infusion unless intermittent dosing has failed***
	Sedation Meds **propofol 1,000 mg/100 mL - Titratable** ☐ IV, Max titration: 5 mcg/kg/min every 5 min, Max dose: 50 mcg/kg/min, Bolus Dose: 25 mg, Bolus Freq: q2h, Bolus 4-hour Limit: 100 mg, Bolus Indication: for sedation Final concentration= 10 mg/mL (10,000 mcg/mL). ***Sedative medications should only be given after pain is adequately controlled*** ☐ Start at rate:_____mcg/kg/min
	Midazolam should NOT be used in patients with creatinine greater than 2 and/or for more than 72 hours **midazolam 100 mg/100 mL NS - Titratable** ☐ Start at rate:_____mg/hr ☐ IV, Max titration: 1 mg/hr every 5 minutes, Max dose: 8 mg/hr Final concentration = 1 mg/mL (1,000 mcg/mL). ***Do NOT initiate infusion unless intermittent dosing has failed*** ***Sedative medications should only be given after pain is adequately controlled***
	LORazepam 40 mg/250 mL D5W - Titratable ☐ Start at rate:_____mg/hr ☐ IV, Max titration: 1 mg/hr every 10 minutes, Max dose: 8 mg/hr Final concentration = 0.16 mg/mL (160 mcg/mL). ***Do NOT initiate infusion unless intermittent dosing has failed*** ***Sedative medications should only be given after pain is adequately controlled***
	dexmedetomidine 400 mcg/100 mL - Titrata (dexmedetomidine 400 mcg/100 mL - Titratable) ☐ IV, Max titration: 0.1 mcg/kg/hr every 30 minutes, Max dose: 1.5 mcg/kg/hr Final concentration = 4 mcg/mL. ***Sedative medications should only be given after pain is adequately controlled*** Continued on next page....

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Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ICU SEDATION AND PAIN 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:_____mcg/kg/hr
	ketamine 500 mg/100 mL NS - Titratable ☐ Start at rate:_____mcg/kg/min ☐ IV, Max titration: 2 mcg/kg/min every every 10 minutes, Max dose: 20 mcg/kg/min Infuse slowly with inotropes amiodarone or milrinone or in patients that are hypertensive.
	Laboratory
	If patient remains on a propofol infusion after 48 hours monitor Triglycerides now and every 3 days until propofol discontinued. **Triglycerides**
	Notify Provider (Misc) (Notify Provider of Results) ☐ Reason: Triglyceride Level greater than 400 mg/dL

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Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ICU PARALYTIC 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
	Apply Peripheral Nerve Stimulator
	Brain Function Monitoring (Apply Brain Function Monitor) ☐ Maintain from 45-60 for optimal range of sedation/anesthesia. Change monitor strip every 24 hours to maintain skin integrity and optimal functioning of monitoring system
	Guideline
	Neuromuscular Blocking Agent Guidelines ☐ ***See Reference Text***
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	ocular lubricant ☐ 1 app, both eyes, ophth oint, as needed, PRN dry eyes
	Paralytic
	Do not perform wake up trials while patient is on paralytic **vecuronium** ☐ 0.08 mg/kg, IVPush, inj, ONE TIME ☐ 0.1 mg/kg, IVPush, inj, ONE TIME
	vecuronium 100 mg/100 mL NS - Titratable ☐ IV, Max titration: 0.1 mcg/kg/min every 10 min, Max dose: 1.7 mcg/kg/min Final concentration = 1 mg/mL (1,000 mcg/mL). Do NOT turn off sedation while paralytic infusion is infusing ☐ Start at rate:_____mcg/kg/min
	cisatracurium ☐ 0.15 mg/kg, IVPush, inj, ONE TIME
	cisatracurium 100 mg/250 mL NS - Titrata (cisatracurium 100 mg/250 mL NS - Titratable) ☐ IV, Max titration: 2 mcg/kg/min every 10 min, Max dose: 10 mcg/kg/min Final concentration = 0.4 mg/mL (400 mcg/mL). Do NOT turn off sedation while paralytic infusion is infusing ☐ Start at rate:_____mcg/kg/min
	rocuronium ☐ 0.6 mg/kg, IVPush, inj, ONE TIME ☐ 1 mg/kg, IVPush, inj, ONE TIME
	rocuronium 100 mg/100 mL NS - Titratable ☐ IV, Max titration: 1 mcg/kg/min every 2 min, Max dose: 16 mcg/kg/min Final concentration = 1 mg/mL (1,000 mcg/mL). Do NOT turn off sedation while paralytic infusion is infusing Continued on next page....

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Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ICU PARALYTIC 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:_____mcg/kg/min

☐ **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 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 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. 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.
	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 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
	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. 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.
	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. Repeat serum magnesium level 2 hours after the infusion is 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
	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. 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

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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

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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 201-250 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 201-250 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 201-250 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 201-250 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 201-250 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

INSULIN DRIP PLAN NON DKA

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
	Insulin Drip Protocol ☐ ***See Reference Text***
	LOW Target Blood Glucose ☐ 120 mg/dL ☐ 140 mg/dL
	HIGH Target Blood Glucose ☐ 140 mg/dL ☐ 160 mg/dL ☐ 180 mg/dL
	POC Blood Sugar Check ☐ q1h, by fingerstick, CVL, or arterial line. DO NOT alternate sites without Physician approval.
	Communication
	Notify Provider (Misc) (Notify Provider of Results) ☐ Reason: Blood Glucose less than 60 mg/dL or greater than 200 mg/dL, also notify if two consecutive BG's less than 70 mg/dL.
	Notify Provider (Misc) ☐ Reason: If other physicians order insulin subQ, IV, or in TPN, feedings are started, stopped, or changed, or if other physicans turn off drip for any reason.
	Notify Provider (Misc) ☐ T;N, Reason: If multiplier remains stable for 8 consecutive hours, consider transition to long acting insulin
	Notify Nurse (DO NOT USE FOR MEDS) ☐ Obtain Serum Blood Glucose if Accucheck is less than 40 mg/dL or greater than 450 mg/dL. However, do not wait for lab results to treat glucose level according to the orders for hypoglycemia
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	insulin R 100 units/100 mL NS ☐ IV Insulin Drip Formula: (BG - 60) x 0.03 = number of UNITS insulin/hour BG = Current Blood Glucose 0.03 = "multiplier" ☐ Start at rate:_____units/hr
	glucose (D50) ☐ 25 g, IVPush, syringe, as needed, PRN low blood sugar If blood glucose is less than 60 mg/dL, administer 25 g D50W. Recheck level in 15 minutes. Repeat dose if still less than 60 mg/dL and contact provider. Continued on next page....

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System INSULIN DRIP PLAN NON DKA	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
	To determine the insulin glargine (Lantus) dose, average the last 8 hours of the insulin drip to units per hour. Multiply this times 20. ***If insulin glargine (Lantus) dose is greater than 60 units, the dose should be split in half and given BID. One injection should not be more than 60 units.*** **insulin glargine** ☐ units, subcut, inj, Daily Administer the initial dose of Lantus 2 hours PRIOR to discontinuing the insulin drip. Dose to be reassessed by physician every 24 hours. ☐ units, subcut, inj, BID Administer the initial dose of Lantus 2 hours PRIOR to discontinuing the insulin drip. Dose to be reassessed by physician every 24 hours.

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ALBUMIN 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.
	Albumin Unapproved Indications - Hypoalbuminemia/Intravenous nutrient - Hypoproteinemic conditions associated with cirrhosis, malabsorption, protein losing enteropathies, pancreatic insufficiency and malnutrition - Hypovolemia responsive to colloids - Ascites responsive to diuretics - Major trauma - Abdominal compartment syndrome - Acute or Chronic pancreatitis - Acute normovolemic hemodilution in surgery - Ovarian hyperstimulation syndrome Albumin Approved Indications Ascites/Large volume paracentesis in patients with cirrhosis: For ascites removal of greater than or equal to 5 liters. Administer albumin 25% (6-8 grams) for each liter of ascitic fluid removed. Crystalloids should be used for volume resuscitation for paracentesis less than 5 liters. **albumin human (albumin human 25% intravenous solution)** ☐ 50 g, IVPB, ivpb, ONE TIME, Infuse over 2 hr, Ascites/Lrg vol paracentesis & cirrhosis Administer immediately AFTER paracentesis
	Plasmapheresis: For large volume plasma exchange of greater than 20 mL/kg in one session or repeated sessions. Replace volume of plasma removed with the infusion of the same volume of 5% albumin. **albumin human (albumin human 5% intravenous solution)** ☐ 12.5 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr, Plasmapheresis ☐ 25 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr, Plasmapheresis
	Spontaneous Bacterial Peritonitis (SBP): For SBP, place BOTH of the following orders for albumin to be given on Day 1 (Max Dose = 150 g) and Day 3 (Max Dose = 100 g). For Day 1: **albumin human (albumin human 25% intravenous solution)** ☐ 1.5 g/kg, IVPB, ivpb, ONE TIME, Max Dose = 150 g, Spontaneous Bacterial Peritonitis (SBP) To be given on Day 1. Max dose of 150 g.
	For Day 3: **albumin human (albumin human 25% intravenous solution)** ☐ 1 g/kg, IVPB, ivpb, ONE TIME, Max Dose = 100 g, Spontaneous Bacterial Peritonitis (SBP) To be given on Day 3. Max dose of 100 g.
	Type I Hepatorenal Syndrome (HRS): For DIAGNOSIS of HRS - Lack of improvement in renal function after stopping diuretics and administration of albumin 1 g/kg (Max Dose = 100 g) daily for two consecutive days.

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ALBUMIN 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
	albumin human (albumin human 25% intravenous solution) ☐ 1 g/kg, IVPB, ivpb, q24h, x 2 dose, Max Dose = 100 g, Type I Hepatorenal Syndrome (HRS) For diagnosis of Type 1 Hepatorenal Syndrome to be given on 2 consecutive days. Max dose is 100 g.
	For TREATMENT of Type I HRS - Beginning on Day 3, administer albumin 25% 25-50 g daily. Octreotide and midodrine should be ordered concomitantly with albumin. Stop albumin when octreotide and midodrine are no longer needed. **albumin human (albumin human 25% intravenous solution)** ☐ 25 g, IVPB, ivpb, q24h, Infuse over 1 hr, Type I Hepatorenal Syndrome (HRS) For Treatment of Type I HRS - Beginning on Day 3, administer albumin 25% 25-50 g daily. Octreotide and midodrine should be ordered concomitantly with albumin. Stop albumin when octreotide and midodrine are no longer needed. ☐ 50 g, IVPB, ivpb, q24h, Infuse over 2 hr, Type I Hepatorenal Syndrome (HRS) For Treatment of Type I HRS - Beginning on Day 3, administer albumin 25% 25-50 g daily. Octreotide and midodrine should be ordered concomitantly with albumin. Stop albumin when octreotide and midodrine are no longer needed.
	Major Hepatic Resection (greater than 40% resected): May give in patients with serum albumin less than 2.5 g/dL, if crystalloids alone fail to achieve adequate intravascular volume. May give daily until albumin is greater than or equal to 2.5 g/dL (up to 4 days). **albumin human (albumin human 25% intravenous solution)** ☐ 25 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr, Major Hepatic Resection (>40% resected)
	Shock May use albumin after 4 L or more of crystalloid have been administered without desired response. **albumin human (albumin human 5% intravenous solution)** ☐ 12.5 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr, Shock
	Acute Nephrosis Approved for use after failure of diuretic alone. **albumin human (albumin human 25% intravenous solution)** ☐ 25 g, IVPB, ivpb, q24h, x 7 days, Infuse over 1 hr, Acute Nephrosis
	Acute Lung Injury (ALI)/Acute Respiratory Distress Syndrome (ARDS) The combination of albumin and diuretics may be considered in patients with hypo-oncotic ALI/ARDS. May give up to 72 hours. **albumin human (albumin human 25% intravenous solution)** ☐ 25 g, IVPB, ivpb, q8h, x 3 dose, Infuse over 1 hr, ALI/ARDS
	Cerebral ischemia or hemorrhage as part of triple H therapy Crystalloid and colloid may be used to maintain normovolemia or hypervolemia as follows: Aneurysmal Subarachnoid Hemorrhage (SAH): Total fluids should be adjusted to maintain target CVP of 6 to 8 to decrease risk of vasospasm. If delayed vasospasm occurs, hypervolemia should be induced to maintain CVP goal of 8 to 12. For acute ischemic stroke or TIA, use albumin if there is evidence of flow failure. **albumin human (albumin human 5% intravenous solution)** ☐ 12.5 g, IVPB, ivpb, q2h, PRN other, CV ischemia/hemorrhage- triple H therapy To be administered as instructed by provider for maintaining volume status.

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

UMC Health System ALBUMIN 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
	Cardiac Surgery Postoperative Volume Resuscitation Replace volume as clinically indicated with 5% albumin in early post-op period (up to 3 hrs). If large volumes are required, change to normal saline after 1,500 mL of albumin have been given. **albumin human (albumin human 5% intravenous solution)** ☐ 12.5 g, IVPB, ivpb, q2h, PRN hypovolemia, Card Surg (post-op volume resuscitation) For volume up to _____ mL
	Thermal Injury Crystalloid solutions should be used for initial fluid resuscitation (within the first 24 hours). Colloids may be administered in conjunction with crystalloids if burn is greater than 50% BSA, 24 hours have passed since the burn occurrence, AND hypovolemia has not corrected with crystalloid alone. Initial dose of 25 grams of albumin (500 mL of 5% solution) is recommended; May be repeated one time. **albumin human (albumin human 5% intravenous solution)** ☐ 12.5 g, IVPB, ivpb, q2h, PRN hypovolemia, x 4 dose, Thermal Injury
	Dialysis associated hypotension Albumin should only be used if fluid bolus fails or is contraindicated. **albumin human (albumin human 25% intravenous solution)** ☐ 12.5 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr, Dialysis associated hypotension ☐ 25 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr, Dialysis associated hypotension
	Other Indications If albumin is needed for an indication other than those listed, please identify it within the order comments field for indication on the order. **albumin human (albumin human 5% intravenous solution)** ☐ 12.5 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr, Other ☐ 25 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr, Other
	albumin human (albumin human 25% intravenous solution) ☐ 12.5 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr, Other ☐ 25 g, IVPB, ivpb, ONE TIME, Infuse over 1 hr, Other

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