UMC Health System

GENERAL UROLOGY 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
	Vital Signs ☐ Per Unit Standards
	Strict Intake and Output ☐ Per Unit Standards ☐ q4h ☐ q12h
	Patient Activity ☐ Assist as Needed | Up in Chair, With Meals ☐ Up Ad Lib/Activity as Tolerated | Assist as Needed ☐ Bathroom Privileges | Assist as Needed
	Ambulate Patient ☐ Ambulate in Room, QID, In Room or Hallway ☐ Ambulate in Room, 5 x per day in room or in hallway
	Insert Urinary Catheter ☐ Foley, To: Dependent Drainage Bag
	Irrigate Foley (Irrigate Urinary Catheter) ☐ T;N, mL of: Normal Saline, q4h and PRN, Use a 60 mL irrigation syringe. Disconnect the drainage bag, add 60 to 120 mL normal saline through the main channel and gently irrigate. Perform until urine clears.
	Urinary Catheter Care
	Discontinue Urinary Catheter ☐ DC Foley, then check Post Void Residual
	Perform Bladder Scan (Check Post Void Residual) ☐ T;N, Remove catheter. Allow pt to void, scan for residual. Record. Repeat x2. If no voiding after 4 hrs, scan bladder. If amt in bladder is greater than 500 mL call MD. If amt in bladder is less than 500 mL, give 2 hrs to void. If pt can't void, call
	Continuous Bladder Irrigation ☐ CBI with NS. Titrate to keep urine pink to clear. Keep 3 bags of 3 L NS in room at all times. Do Not let CBI run dry.
	Communication
	Notify Provider/Primary Team of Pt Admit ☐ In AM ☐ Now ☐ Upon Arrival to Unit
	Strain All Urine
	Notify Provider of VS Parameters ☐ Temp Greater Than 102 degrees, SBP Greater Than 90 mmHg
	Notify Provider (Misc) ☐ Reason: Urine Output less than 120 mL/4 hrs
	Instruct Patient ☐ Instruct Patient On: Incentive spirometry
	Notify Nurse (DO NOT USE FOR MEDS) ☐ T;N, Elevate scrotum with towel while in bed and with supportive jock strap while ambulating.

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System

GENERAL UROLOGY 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
	Notify Nurse (DO NOT USE FOR MEDS) ☐ T;N, Apply Neosporin on penile meatus, may substitute vasoline if patient is intolerant of Neosporin.
	Notify Nurse (DO NOT USE FOR MEDS) ☐ T;N, "Rack Urine" Keep a urine sample from each void in a specimen cup. Keep in patient's room unitl the urine is evaluated by the urology team.
	Notify Nurse (DO NOT USE FOR MEDS) ☐ T;N, Apply ice pack to scrotum TID and as needed for discomfort.
	Dietary
	Oral Diet ☐ Regular Diet ☐ Renal (Dialysis) Diet ☐ Clear Liquid Diet ☐ Clear Liquid Diet, Advance as tolerated to Full Liquid ☐ Clear Liquid Diet, Advance as tolerated to Heart Healthy ☐ Clear Liquid Diet, Advance as tolerated to Renal (Non-Dialysis) ☐ Carbohydrate Controlled (1200 calories) Diet ☐ Carbohydrate Controlled (2000 calories) Diet ☐ Heart Healthy Diet ☐ Renal (Non-Dialysis) Diet ☐ Full Liquid Diet ☐ Clear Liquid Diet, Advance as tolerated to Regular ☐ Clear Liquid Diet, Advance as tolerated to Renal (Dialysis) ☐ Carbohydrate Controlled (1600 calories) Diet
	NPO Diet ☐ NPO ☐ T;2359, NPO After Midnight, Except Meds ☐ T;2359, NPO After Midnight
	IV Solutions
	D5 1/2 NS + 20 mEq KCl/L ☐ IV, 75 mL/hr ☐ IV, 125 mL/hr ☐ IV, 100 mL/hr ☐ IV, 150 mL/hr
	1/2 NS ☐ IV, 75 mL/hr ☐ IV, 125 mL/hr ☐ IV, 100 mL/hr ☐ IV, 150 mL/hr
	NS (Normal Saline) ☐ IV, 75 mL/hr ☐ IV, 125 mL/hr ☐ IV, 100 mL/hr ☐ IV, 150 mL/hr
	D5 1/2 NS ☐ IV, 75 mL/hr ☐ IV, 125 mL/hr ☐ IV, 100 mL/hr ☐ IV, 150 mL/hr
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	tamsulosin ☐ 0.4 mg, PO, cap, Nightly Give 30 min after meal. Do not crush or chew.
	oxybutynin ☐ 5 mg, PO, tab, TID

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System GENERAL UROLOGY 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
	phenazopyridine ☐ 100 mg, PO, tab, TID, x 9 dose Max 9 doses
	Gastrointestinal Agents
	Place both of the orders below for magnesium citrate if two doses are needed. The first order will schedule a dose for 1300. The second order will schedule a dose for 1700. **magnesium citrate** ☐ 300 mL, PO, liq, ONE TIME at 1300 ☐ 600 mL, PO, liq, ONE TIME at 1300
	magnesium citrate ☐ 300 mL, PO, liq, ONE TIME at 1700 ☐ 600 mL, PO, liq, ONE TIME at 1700
	Other Medications
	probiotic, multistrain ☐ 1 cap, PO, cap, Daily
	Laboratory
	CBC ☐ Routine, T;N
	CBC ☐ Next Day in AM, T+1;0300, Every AM for 3 days
	Prothrombin Time with INR
	PTT
	Basic Metabolic Panel
	Renal Function Panel ☐ Routine, T;N
	Renal Function Panel ☐ Next Day in AM, T+1;0300, Every AM for 3 days
	Comprehensive Metabolic Panel
	Urinalysis
	Culture Urine
	Diagnostic Tests
	EKG-12 Lead
	DX Chest PA & Lateral
	DX Abdomen AP (KUB)

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System GENERAL UROLOGY 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**
	US Renal
	US Aorta Retroperitoneal
	CT Abd, Pel w/o Contrast
	CT Abd w/wo, Pel w/ IV Contrast Only
	Respiratory
	Oxygen (O2) Therapy ☐ 2-3 L/min, Via: Nasal cannula
	IS Instruct
	Respiratory Care Plan Guidelines
	Consults/Referrals
	Consult MD
	...Additional Orders

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System

ASP THERAPY FOR URINARY TRACT INFECTION 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
	Urine Antibiogram
	Antibiogram Education ☐ T;N, Routine, See link for reference text.
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	Acute Uncomplicated Cystitis Women For UNCOMPLICATED UTI in women that warrants treatment (dysuria, frequency, and urgency plus urinalysis confirmation), select oral therapy as either cefdinir or nitrofurantoin. If early pyelonephritis suspected, treat as pyelonephritis and reference that section below. **cefdinir** ☐ 300 mg, PO, cap, BID, x 5 days
	nitrofurantoin (nitrofurantoin monohydrate 100 mg oral capsule) ☐ 100 mg, PO, cap, BID, x 5 days
	Acute Complicated Cystitis Men or Women (diabetic, pregnant, chronic foley catheter, obstruction, anatomic abnormalities , immunosuppression) Select ONE of the following: **cefTRIAXone** ☐ 1 g, IVPush, inj, q24h, x 7 days Reconstitute with 10 mL of sterile water or NS. Administer IV Push over 3 minutes.
	ampicillin-sulbactam ☐ 3 g, IVPB, ivpb, q6h, x 7 days, Infuse over 30 min, Genitourinary infection
	Alternatively, if patient has an allergy to penicillin or cephalosporin choose either gentamicin or aztreonam **gentamicin** ☐ 5 mg/kg, IVPB, ivpb, q24h, x 7 days, Infuse over 60 min, [MONITORING ADVISED] Pharmacy to dose and monitor
	aztreonam ☐ 2 g, IVPush, inj, q8h, x 7 days
	Pyelonephritis Select ONE of the following: **cefepime** ☐ 1 g, IVPB, ivpb, q12h, x 14 days, Infuse over 30 min, Genitourinary infection
	piperacillin-tazobactam ☐ 3.375 g, IVPB, ivpb, q6h, x 14 days, Infuse over 30 min
	Alternatively, if patient has an allergy to penicillin or cephalosporin, select aztreonam **aztreonam** ☐ 2 g, IVPush, inj, q8h, x 14 days Reconstitute with 10 mL of Sterile Water or NS Administer IV Push over 3-5 minutes Continued on next page....

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System

ASP THERAPY FOR URINARY TRACT INFECTION 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

☐ **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

Patient Label Here

BB TRANSFUSE BLOOD PRODUCT FOR PTS 25 KG OR GREATER

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
	CRITICAL BLOOD SHORTAGE *****Due to a blood shortage both locally and nationally, strongly consider the indications and evidence for this transfusion prior to placing the order. Transfusion guidelines are attached to each order below. *** ***Select the product to transfuse and the post transfusion lab, if applicable*** **BB PRBC for pts 25 kg or GREATER** ☐ Priority: To Transfuse When Ready, 1 units ☐ Priority: To Transfuse When Ready, 2 units
	BB Platelet for pts 25 kg or GREATER ☐ Priority: To Transfuse When Ready, 1 units
	BB Plasma for pts 25 kg or GREATER ☐ Priority: To Transfuse When Ready, 1 units ☐ Priority: To Transfuse When Ready, 2 units
	BB Cryoprecipitate for pts 25 kg or GREA (BB Cryoprecipitate for pts 25 kg or GREATER) ☐ Priority: To Transfuse When Ready, Type of Cryo: Single Non Pooled ☐ Priority: To Transfuse When Ready, Type of Cryo: 5 Pack Pooled
	Select the following order to transfuse in hemodialysis ***Select the medication(s) to be given, if applicable*** ***Medications to be given prior to infusion*** ***Medication to be given in between units*** ***Medication to be given after all units transfused***

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ASP THERAPY FOR URINARY TRACT INFECTION AS SEPSIS SOURCE	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
	Urine Antibiogram
	Antibiogram Education ☐ T;N, Routine, See link for reference text.

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System

BB TRANSFUSE BLOOD PRODUCT FOR PTS 25 KG OR GREATER

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
	Transfusion Instructions For Nursing (DO (Transfusion Instructions For Nursing (DO NOT USE FOR MEDS)) ☐ Transfuse in Hemodialysis with next treatment

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System

ASP THERAPY FOR URINARY TRACT INFECTION AS SEPSIS SOURCE

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.
	Choose ONE of the following antibiotics If ordering piperacillin-tazobactam, place order for BOTH items **piperacillin-tazobactam** ☐ 3.375 g, IVPB, ivpb, ONE TIME, Infuse over 30 min
	piperacillin-tazobactam ☐ 3.375 g, IVPB, ivpb, q8h, Infuse over 4 hr, 4 hour extended infusion, Genitourinary infection
	cefepime ☐ 2 g, IVPB, ivpb, q8h, Infuse over 3 hr, Genitourinary infection Reconstitute with 10-20 mL of Sterile Water or NS Administer IV Push over 3 minutes
	cefTRIAXone ☐ 1 g, IVPush, inj, q12h Reconstitute with 10 mL of Sterile Water or NS Administer IV Push over 3 minutes
	acetaminophen ☐ 325 mg, PO, tab, Transfusion Med, PRN blood product infusions, x 1 dose Give prior to transfusion ☐ 500 mg, PO, tab, Transfusion Med, PRN blood product infusions, x 1 dose Give prior to transfusion ☐ 10 mg/kg, PO, liq, Transfusion Med, PRN blood product infusions, x 1 dose Give prior to transfusion ☐ 15 mg/kg, PO, liq, Transfusion Med, PRN blood product infusions, x 1 dose Give prior to transfusion
	diphenhydrAMINE ☐ 25 mg, IVPush, inj, Transfusion Med, PRN blood product infusions, x 1 dose Give prior to transfusion. ☐ 50 mg, IVPush, inj, Transfusion Med, PRN blood product infusions, x 1 dose Give prior to transfusion. ☐ 1 mg/kg, IVPush, inj, Transfusion Med, PRN blood product infusions, x 1 dose, Max Dose = 50 mg Give prior to transfusion. Max Dose = 50 mg
	furosemide ☐ 40 mg, IVPush, inj, Transfusion Med, PRN blood product infusions, x 1 dose Give between units. ☐ 1 mg/kg, IVPush, inj, Transfusion Med, PRN blood product infusions, x 1 dose, Max Dose = 40 mg Give in between units. Max Dose = 40 mg Continued on next page....

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System ASP THERAPY FOR URINARY TRACT INFECTION AS SEPSIS SOURCE	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
	furosemide ☐ 40 mg, IVPush, inj, Transfusion Med, PRN blood product infusions, x 1 dose Give after all units have been transfused. ☐ 1 mg/kg, IVPush, inj, Transfusion Med, PRN blood product infusions, x 1 dose, Max Dose = 40 mg Give after all units have been transfused. Max Dose = 40 mg

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

Order Taken by Signature: _____ Date _____ Time _____

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

UMC Health System

BB TRANSFUSE BLOOD PRODUCT FOR PTS 25 KG OR GREATER

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
	Post Transfusion H and H ☐ STAT, Comment: Draw TWO hours after TRANSFUSION IS complete
	Post Transfusion Platelet Count ☐ STAT, Comment: Draw After Transfusion
	Post Transfusion PT with INR ☐ STAT, Comment: Draw After Transfusion
	Post Transfusion Fibrinogen ☐ STAT, Comment: Draw After Transfusion

☐ **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*** If acetaminophen contraindicated or ineffective, use ibuprofen if ordered. ☐ 1,000 mg, PO, tab, q6h, PRN fever ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours*** If acetaminophen contraindicated or ineffective, use ibuprofen if ordered.
	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*** If acetaminophen contraindicated or ineffective, use ibuprofen if ordered. Continued on next page....

☐ **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**
	☐ 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*** If acetaminophen contraindicated or ineffective, use ibuprofen if ordered. ☐ 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*** If acetaminophen contraindicated or ineffective, use ibuprofen if ordered.
	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*** If hydrocodone/acetaminophen contraindicated or ineffective, use ____ if ordered. ☐ 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*** If hydrocodone/acetaminophen contraindicated or ineffective, use ____ if ordered.
	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*** If acetaminophen/codeine contraindicated or ineffective , use ____ if ordered. ☐ 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*** If acetaminophen/codeine contraindicated or ineffective , use ____ if ordered.
	traMADol ☐ 50 mg, PO, tab, q6h, PRN pain-moderate (scale 4-6) If tramadol contraindicated or ineffective, use ____ if ordered. ☐ 50 mg, PO, tab, q4h, PRN pain-moderate (scale 4-6) If tramadol contraindicated or ineffective, use ____ if ordered.
	ketorolac ☐ 15 mg, IVPush, inj, q6h, PRN pain-moderate (scale 4-6), x 48 hr ***May give IM if no IV access*** If ketorolac contraindicated or ineffective, use ____ if ordered.
	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) If morphine contraindicated or ineffective, use hydromorphone if ordered. ☐ 4 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 7-10) If morphine contraindicated or ineffective, use hydromorphone if ordered.

☐ **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
	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 **promethazine** ☐ 25 mg, PO, tab, q4h, PRN nausea
	ondansetron ☐ 4 mg, IVPush, soln, q8h, PRN nausea If ondansetron contraindicated or ineffective, use promethazine if ordered. ☐ 4 mg, IVPush, soln, q6h, PRN nausea If ondansetron contraindicated or ineffective, use promethazine if ordered.
	Gastrointestinal Agents
	Select only ONE of the following for constipation **docusate** ☐ 100 mg, PO, cap, Nightly, PRN constipation If docusate contraindicated or ineffective, use bisacodyl if ordered. ☐ 100 mg, PO, cap, Daily Do not crush or chew.
	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
	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

☐ **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
	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

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
	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

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 4 hours. **ibuprofen** ☐ 400 mg, PO, tab, q8h, x 3 days To be alternated with acetaminophen every 4 hours.
	acetaminophen ☐ 500 mg, PO, tab, q8h, x 3 days To be alternated with ibuprofen every 4 hours. Do not exceed 4000 mg of acetaminophen per day from all sources.
	For renally impared patients: The following scheduled orders will alternate every 4 hours. **traMADol** ☐ 50 mg, PO, tab, q8h, x 3 days To be alternated with acetaminophen every 4 hours.
	acetaminophen ☐ 500 mg, PO, tab, q8h, x 3 days To be alternated with tramadol every 4 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

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 contraindicated **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** _____