

ORTHO REPLANTATION/FLAP POST-OP PLAN  
- Phase: PACU Phase

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

Peripheral Nerve Block

Laboratory

CBC with Differential

STAT Outpatient/PACU, T;N

PTT

STAT Outpatient/PACU, T;N

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Order Taken by Signature: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_



<b>UMC Health System</b>  <b>ORTHO REPLANTATION/FLAP POST-OP PLAN</b> - Phase: Upon Arrival to Room	<b>Patient Label Here</b>
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**PHYSICIAN ORDERS**

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	<b>Patient Care</b>
	<b>Patient Activity</b> <input type="checkbox"/> Bedrest
	<b>Vital Signs</b> <input type="checkbox"/> Per Unit Standards
	<b>Perform Neurovascular Checks</b> <input type="checkbox"/> To: Operative Extremity, q1h, Check pulses with doppler q1hour. Check to include color, capillary refill and temperature of extremity.
	<b>Strict Intake and Output</b> <input type="checkbox"/> T;N, q8h, for 48 hours
	<b>Elevate Extremity</b> <input type="checkbox"/> Operative Extremity, Recipient site elevated higher than next proximal joint
	<b>Elevate Extremity</b> <input type="checkbox"/> Operative Extremity, Elevated carefully in well padded sling with elbow at bed level and hand comfortably elevated
	<b>Urinary Catheter Care</b>
	<b>Communication</b>
	<b>Notify Provider (Misc) (Notify Provider of Results)</b> <input type="checkbox"/> T;N, Reason: Any changes in neurovascular checks of the affected limb or flap, if the doppler signals changes, or if the temperature shows a prolonged downward decline.
	<b>Notify Provider (Misc) (Notify Provider of Results)</b> <input type="checkbox"/> T;N, Reason: Any changes in neurovascular checks of the affected limb or flap, if the doppler signals changes, or if the temperature shows a prolonged downward decline.
	<b>Notify Nurse (DO NOT USE FOR MEDS)</b> <input type="checkbox"/> T;N, Room temperature to be kept greater than 80 degrees at all times.
	<b>Notify Nurse (DO NOT USE FOR MEDS)</b> <input type="checkbox"/> T;N, Patient to be kept calm with attempt to avoid all painful stimuli, loud noises etc.
	<b>Notify Nurse (DO NOT USE FOR MEDS)</b> <input type="checkbox"/> T;N, Sign to be posted: NO COFFEE, TEA, CAFFEINE, CHOCOLATE, OR SMOKING.
	<b>Instruct Patient</b> <input type="checkbox"/> T;N, Instruct Patient On: Incentive spirometry
	<b>Dietary</b>
	<b>NPO Diet</b> <input type="checkbox"/> on POD 0. Advance diet on POD 1 at physician's direction.
	<b>IV Solutions</b>

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
- Phase: Upon Arrival to Room

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
	<p><b>D5LR</b></p> <p><input type="checkbox"/> IV, 75 mL/hr <input type="checkbox"/> IV, 100 mL/hr</p> <p><input type="checkbox"/> IV, 125 mL/hr <input type="checkbox"/> IV, 150 mL/hr</p> <p><input type="checkbox"/> IV, 25 mL/hr</p>
	<p><b>LR</b></p> <p><input type="checkbox"/> IV, 75 mL/hr <input type="checkbox"/> IV, 100 mL/hr</p> <p><input type="checkbox"/> IV, 125 mL/hr <input type="checkbox"/> IV, 150 mL/hr</p> <p><input type="checkbox"/> IV, 25 mL/hr</p>
	<p><b>NS</b></p> <p><input type="checkbox"/> IV, 75 mL/hr <input type="checkbox"/> IV, 100 mL/hr</p> <p><input type="checkbox"/> IV, 125 mL/hr <input type="checkbox"/> IV, 150 mL/hr</p> <p><input type="checkbox"/> IV, 25 mL/hr</p>
	<p>***Calculate the heparin rate so the Total Hourly Dose equals 400 units per hour***</p> <p><b>heparin 25,000 units/250 mL D5W</b></p> <p><input type="checkbox"/> IV</p> <p>**Total hourly dose should equal 400 units/hr**</p> <p>Final Concentration: 100 units/mL</p> <p><input type="checkbox"/> Start at rate: _____ units/hr</p> <p>For Ortho Replantation/Flap Procedure</p>
<b>Medications</b>	
Medication sentences are per dose. You will need to calculate a total daily dose if needed.	
	<p><b>aspirin</b></p> <p><input type="checkbox"/> 325 mg, PO, tab, Daily</p>
<b>Antacids</b>	
	<p><b>Al hydroxide-Mg hydroxide-simethicone (aluminum hydroxide-magnesium hydroxide-simethicone 200 mg-200 mg-20 mg/5 mL oral suspension)</b></p> <p><input type="checkbox"/> 30 mL, PO, susp, Daily, PRN indigestion</p>
<b>Anxiety</b>	
	<p><b>chlorproMAZINE</b></p> <p><input type="checkbox"/> 25 mg, PO, tab, TID, PRN agitation</p>
<b>Analgesics</b>	
	<p>***Mild Pain***</p> <p><b>oxyCODONE-acetaminophen (oxyCODONE-acetaminophen 5 mg-325 mg oral tablet)</b></p> <p><input type="checkbox"/> 1 tab, PO, tab, q4h, PRN pain-mild (scale 1-3)</p> <p>Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours.</p>
	<p>***Moderate Pain***</p> <p><b>oxyCODONE-acetaminophen (oxyCODONE-acetaminophen 5 mg-325 mg oral tablet)</b></p> <p><input type="checkbox"/> 2 tab, PO, tab, q4h, PRN pain-moderate (scale 4-7)</p> <p>Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours.</p>
<b>Laboratory</b>	

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
- Phase: Upon Arrival to Room

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ORDER	ORDER DETAILS
	<b>Prothrombin Time with INR (PT with INR)</b> <input type="checkbox"/> Next Day in AM, Every AM 3 days
	<b>PTT</b> <input type="checkbox"/> Next Day in AM, Every AM 3 days
<b>Respiratory</b>	
	<b>Respiratory Care Plan Guidelines</b>
	<b>Oxygen Therapy</b> <input type="checkbox"/> 2-3 Liters L/min, Via: Nasal cannula
<b>Consults/Referrals</b>	
	<b>Consult MD</b>
<b>...Additional Orders</b>	

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
 - Phase: ORTHO POST-OP MEDICATION PLAN FOR  
 PATIENTS 40 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
<b>IV Solutions</b>	
	<b>LR (Lactated Ringer's)</b> <input type="checkbox"/> IV, 75 mL/hr <input type="checkbox"/> IV, 125 mL/hr <input type="checkbox"/> IV, 200 mL/hr <input type="checkbox"/> IV, 100 mL/hr <input type="checkbox"/> IV, 150 mL/hr
	<b>D5 1/2 NS + 20 mEq KCl/L</b> <input type="checkbox"/> IV, 75 mL/hr <input type="checkbox"/> IV, 125 mL/hr <input type="checkbox"/> IV, 200 mL/hr <input type="checkbox"/> IV, 100 mL/hr <input type="checkbox"/> IV, 150 mL/hr
	<b>1/2 NS</b> <input type="checkbox"/> IV, 75 mL/hr <input type="checkbox"/> IV, 125 mL/hr <input type="checkbox"/> IV, 200 mL/hr <input type="checkbox"/> IV, 100 mL/hr <input type="checkbox"/> IV, 150 mL/hr
	<b>NS (Normal Saline)</b> <input type="checkbox"/> IV, 75 mL/hr <input type="checkbox"/> IV, 125 mL/hr <input type="checkbox"/> IV, 200 mL/hr <input type="checkbox"/> IV, 100 mL/hr <input type="checkbox"/> IV, 150 mL/hr
	<b>D5 1/2 NS</b> <input type="checkbox"/> IV, 75 mL/hr <input type="checkbox"/> IV, 125 mL/hr <input type="checkbox"/> IV, 200 mL/hr <input type="checkbox"/> IV, 100 mL/hr <input type="checkbox"/> IV, 150 mL/hr
<b>Medications</b>	
Medication sentences are per dose. You will need to calculate a total daily dose if needed.	
	<b>aspirin</b> <input type="checkbox"/> 81 mg, PO, tab ec, Daily <input type="checkbox"/> 325 mg, PO, tab ec, Daily <input type="checkbox"/> 81 mg, PO, tab ec, BID
	<b>rivaroxaban</b> <input type="checkbox"/> 10 mg, PO, tab, In PM
<b>Antibiotics</b>	
	<b>ceFAZolin</b> <input type="checkbox"/> 1 g, IVPush, inj, q6h, x 3 dose Begin 6 hours after preoperative dose given. Reconstitute with 10 mL of Sterile Water or NS Administer IV Push over 3 minutes <input type="checkbox"/> 2 g, IVPush, inj, q6h, x 3 dose Begin 6 hours after preoperative dose given. Reconstitute each vial with 10 mL of Sterile Water or NS Administer IV Push over 3-5 minutes Continued on next page....

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
 - Phase: ORTHO POST-OP MEDICATION PLAN FOR  
 PATIENTS 40 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
	<p><b>clindamycin</b></p> <p><input type="checkbox"/> 600 mg, IVPB, ivpb, q6h, x 3 dose, Infuse over 30 min                      Begin 6 hours after preoperative dose given.</p> <p><input type="checkbox"/> 900 mg, IVPB, ivpb, q6h, x 3 dose, Infuse over 30 min                      Begin 6 hours after preoperative dose given.</p>
	<p><b>vancomycin</b></p> <p><input type="checkbox"/> 15 mg/kg, IVPB, ivpb, q12h, x 1 dose, Infuse over 90 min                      Begin 12 hours after preoperative dose given.</p>
<b>Scheduled Analgesics</b>	
	<p><b>ketorolac</b></p> <p><input type="checkbox"/> 15 mg, IVPush, inj, q6h, x 48 hr                      ***May give IM if no IV access***</p>
	<p><b>acetaminophen</b></p> <p><input type="checkbox"/> 1,000 mg, IVPB, iv soln, q6h, x 2 dose, Infuse over 15 min                      ***Do not exceed 4,000 mg of acetaminophen from all sources in 24 hours***</p>
<b>PRN Analgesics</b>	
	<p>If ordering scheduled, intravenous acetaminophen for 24 hours, HYDROcodone-acetaminophen orders cannot begin until that order expires. This prevents exceeding the maximum 4000 mg/24 hours of acetaminophen.</p> <p>Select only ONE of the following for Mild Pain</p> <p><b>HYDROcodone-acetaminophen (HYDROcodone-acetaminophen 5 mg-325 mg oral tablet)</b></p> <p><input type="checkbox"/> 1 tab, PO, tab, q4h, PRN pain-mild (scale 1-3)                      If scheduled, intravenous acetaminophen for 24 hours ordered, HYDROcodone-acetaminophen orders cannot begin until that order expires. Do not exceed 4g/day of acetaminophen</p>
	<p><b>HYDROcodone-acetaminophen (HYDROcodone-acetaminophen 7.5 mg-325 mg oral tablet)</b></p> <p><input type="checkbox"/> 1 tab, PO, tab, q4h, PRN pain-mild (scale 1-3)                      If scheduled, intravenous acetaminophen for 24 hours ordered, HYDROcodone-acetaminophen orders cannot begin until that order expires. Do not exceed 4g/day of acetaminophen</p>
	<p>Select only ONE of the following for Moderate Pain</p> <p><b>HYDROcodone-acetaminophen (HYDROcodone-acetaminophen 5 mg-325 mg oral tablet)</b></p> <p><input type="checkbox"/> 2 tab, PO, tab, q4h, PRN pain-moderate (scale 4-7)                      If scheduled, intravenous acetaminophen for 24 hours ordered, HYDROcodone-acetaminophen orders cannot begin until that order expires. Do not exceed 4g/day of acetaminophen.</p> <p>Continued on next page....</p>

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
 - Phase: ORTHO POST-OP MEDICATION PLAN FOR  
 PATIENTS 40 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
	<p><b>HYDROcodone-acetaminophen (HYDROcodone-acetaminophen 7.5 mg-325 mg oral tablet)</b>  <input type="checkbox"/> 2 tab, PO, tab, q4h, PRN pain-moderate (scale 4-7)                      If scheduled, intravenous acetaminophen for 24 hours ordered, HYDROcodone-acetaminophen orders cannot begin until that order expires. Do not exceed 4g/day of acetaminophen.</p>
	<p><b>traMADol</b>  <input type="checkbox"/> 50 mg, PO, tab, q6h, PRN pain-moderate (scale 4-7)                      *****IF traMADol ineffective/contraindicated, USE PRN oxyCODONE if ordered*****  <input type="checkbox"/> 100 mg, PO, tab, q6h, PRN pain-moderate (scale 4-7)                      *****IF traMADol ineffective/contraindicated, USE PRN oxyCODONE if ordered*****</p>
	<p><b>oxyCODONE</b>  <input type="checkbox"/> 5 mg, PO, tab, q4h, PRN pain-moderate (scale 4-7)                      <input type="checkbox"/> 10 mg, PO, tab, q4h, PRN pain-moderate (scale 4-7)</p>
	<p>Select only ONE of the following for Severe Pain</p> <p><b>morphine</b>  <input type="checkbox"/> 2 mg, Slow IVPush, inj, q2h, PRN pain-severe (scale 8-10)                      *****IF morphine is ineffective/contraindicated, USE HYDROmorphine if ordered*****  <input type="checkbox"/> 4 mg, Slow IVPush, inj, q2h, PRN pain-severe (scale 8-10)                      *****IF morphine is ineffective/contraindicated, USE HYDROmorphine if ordered*****</p>
	<p><b>HYDROmorphine</b>  <input type="checkbox"/> 0.2 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 8-10)                      <input type="checkbox"/> 0.5 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 8-10)  <input type="checkbox"/> 1 mg, Slow IVPush, inj, q4h, PRN pain-severe (scale 8-10)</p>
<b>Muscle Relaxant</b>	
	<p>Oral methocarbamol is not FDA approved in patients less than 16 years of age.</p> <p><b>methocarbamol</b>  <input type="checkbox"/> 500 mg, PO, tab, q6h, PRN muscle spasms                      <input type="checkbox"/> 750 mg, PO, tab, q6h, PRN muscle spasms  <input type="checkbox"/> 500 mg, IVPush, inj, q6h, PRN muscle spasms, x 72 hr                      Administer IV Push over 3 minutes.</p> <p>Administer IV while in recumbent position. Maintain position for at least 10-15 minutes following infusion.  <input type="checkbox"/> 750 mg, IVPush, inj, q6h, PRN muscle spasms, x 72 hr                      Administer IV Push over 3 minutes.</p> <p>Administer IV while in recumbent position. Maintain position for at least 10-15 minutes following infusion.</p>
<b>Gastrointestinal Agents</b>	
	<p><b>docusate</b>  <input type="checkbox"/> 100 mg, PO, cap, Nightly, PRN constipation                      *****IF docusate is contraindicated or ineffective after 12 hours, USE bisacodyl if ordered*****  <input type="checkbox"/> 100 mg, PO, cap, BID                      *****IF docusate is contraindicated or ineffective after 12 hours, USE bisacodyl if ordered*****</p>
	<p><b>bisacodyl</b>  <input type="checkbox"/> 10 mg, rectally, supp, Daily, PRN constipation</p>

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
- Phase: SLIDING SCALE INSULIN REGULAR PLAN

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
<b>Patient Care</b>	
<b>POC Blood Sugar Check</b>	
<input type="checkbox"/> Per Sliding Scale Insulin Frequency <input type="checkbox"/> AC & HS 3 days <input type="checkbox"/> BID <input type="checkbox"/> q6h <input type="checkbox"/> q4h	<input type="checkbox"/> AC & HS <input type="checkbox"/> TID <input type="checkbox"/> q12h <input type="checkbox"/> q6h 24 hr
<b>Sliding Scale Insulin Regular Guidelines</b>	
<input type="checkbox"/> Follow SSI Regular Reference Text	
<b>Medications</b>	
<b>Medication sentences are per dose. You will need to calculate a total daily dose if needed.</b>	
<b>insulin regular (Low Dose Insulin Regular Sliding Scale)</b>	
<input type="checkbox"/> 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 insulin regular sliding scale.	
<input type="checkbox"/> 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	
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ORTHO REPLANTATION/FLAP POST-OP PLAN  
- Phase: SLIDING SCALE INSULIN REGULAR PLAN

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	<p><input type="checkbox"/> 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.</p> <p>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</p> <p>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 insulin regular sliding scale.</p> <p><input type="checkbox"/> 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.</p> <p>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</p> <p>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 insulin regular sliding scale.</p> <p><input type="checkbox"/> 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.</p> <p>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</p> <p>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 insulin regular sliding scale.</p> <p>Continued on next page....</p>

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ORDER	ORDER DETAILS
	<p><b>insulin regular (Moderate Dose Insulin Regular Sliding Scale)</b></p> <p><input type="checkbox"/> 0-12 units, subcut, inj, AC &amp; 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.</p> <p>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</p> <p>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.</p> <p><input type="checkbox"/> 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.</p> <p>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</p> <p>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.</p> <p><input type="checkbox"/> 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.</p> <p>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</p> <p>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.</p> <p>Continued on next page....</p>

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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
	<p><input type="checkbox"/> 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.</p> <p>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</p> <p>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.</p> <p><input type="checkbox"/> 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.</p> <p>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</p> <p>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.</p>
	<p><b>insulin regular (High Dose Insulin Regular Sliding Scale)</b></p> <p><input type="checkbox"/> 0-14 units, subcut, inj, AC &amp; 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.</p> <p>70-150 mg/dL - 0 units 151-200 mg/dL - 3 units subcut 200-250 mg/dL - 5 units subcut 251-300 mg/dL - 7 units subcut 301-350 mg/dL - 10 units subcut 351-400 mg/dL - 12 units subcut</p> <p>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.</p> <p>Continued on next page....</p>

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
- Phase: SLIDING SCALE INSULIN REGULAR PLAN

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	<p><input type="checkbox"/> 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.</p> <p>70-150 mg/dL - 0 units 151-200 mg/dL - 3 units subcut 200-250 mg/dL - 5 units subcut 251-300 mg/dL - 7 units subcut 301-350 mg/dL - 10 units subcut 351-400 mg/dL - 12 units subcut</p> <p>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.</p> <p><input type="checkbox"/> 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.</p> <p>70-150 mg/dL - 0 units 151-200 mg/dL - 3 units subcut 200-250 mg/dL - 5 units subcut 251-300 mg/dL - 7 units subcut 301-350 mg/dL - 10 units subcut 351-400 mg/dL - 12 units subcut</p> <p>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.</p> <p><input type="checkbox"/> 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.</p> <p>70-150 mg/dL - 0 units 151-200 mg/dL - 3 units subcut 200-250 mg/dL - 5 units subcut 251-300 mg/dL - 7 units subcut 301-350 mg/dL - 10 units subcut 351-400 mg/dL - 12 units subcut</p> <p>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.</p> <p>Continued on next page....</p>

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
- Phase: SLIDING SCALE INSULIN REGULAR PLAN

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	<input type="checkbox"/> 0-14 units, subcut, inj, q4h, PRN glucose levels - see parameters High Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider.  70-150 mg/dL - 0 units 151-200 mg/dL - 3 units subcut 200-250 mg/dL - 5 units subcut 251-300 mg/dL - 7 units subcut 301-350 mg/dL - 10 units subcut 351-400 mg/dL - 12 units subcut  If blood glucose is greater than 400 mg/dL, administer 14 units subcut, notify provider, and repeat POC blood sugar check in 2 hours. Continue to repeat 10 units subcut and POC blood sugar checks every 2 hours until blood glucose is less than 300 mg/dL. Once blood sugar is less than 300 mg/dL, repeat POC blood sugar in 4 hours and then resume normal POC blood sugar check and insulin regular sliding scale.
	<p><b>insulin regular (Blank Insulin Sliding Scale)</b></p> <input type="checkbox"/> See Comments, subcut, inj, PRN glucose levels - see parameters If 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.
<b>HYPOglycemia Guidelines</b>	
	<p><b>HYPOglycemia Guidelines</b></p> <input type="checkbox"/> ***See Reference Text***
	<p><b>glucose</b></p> <input type="checkbox"/> 15 g, PO, gel, as needed, PRN glucose levels - see parameters If 6 ounces of juice is not an option, may use glucose gel if blood glucose is less than 70 mg/dL and patient is symptomatic and able to swallow. See hypoglycemia Guidelines. Continued on next page....

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
- Phase: SLIDING SCALE INSULIN REGULAR PLAN

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	<p><b>glucose (D50)</b>  <input type="checkbox"/> 25 g, IVPush, syringe, as needed, PRN glucose levels - see parameters            Use if patient is symptomatic and cannot swallow OR if patient has altered mental status.</p>
	<p><b>glucagon</b>  <input type="checkbox"/> 1 mg, IM, inj, as needed, PRN glucose levels - see parameters            Use if patient is symptomatic and cannot swallow/NPO WITHOUT IV access OR if patient has altered mental status.</p>

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
- Phase: VTE PROPHYLAXIS PLAN

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
<b>Patient Care</b>	
	<b>VTE Guidelines</b> <input type="checkbox"/> See Reference Text for Guidelines
	***If VTE Pharmacologic Prophylaxis not given, choose the Contraindications for VTE below and complete reason contraindicated***  <b>Contraindications VTE</b> <input type="checkbox"/> Active/high risk for bleeding <input type="checkbox"/> Patient or caregiver refused <input type="checkbox"/> Anticipated procedure within 24 hours <input type="checkbox"/> Treatment not indicated <input type="checkbox"/> Other anticoagulant ordered <input type="checkbox"/> Intolerance to all VTE chemoprophylaxis
	<b>Apply Elastic Stockings</b> <input type="checkbox"/> Apply to: Bilateral Lower Extremities, Length: Knee High <input type="checkbox"/> Apply to: Right Lower Extremity (RLE), Length: Knee High <input type="checkbox"/> Apply to: Left Lower Extremity (LLE), Length: Thigh High <input type="checkbox"/> Apply to: Left Lower Extremity (LLE), Length: Knee High <input type="checkbox"/> Apply to: Bilateral Lower Extremities, Length: Thigh High <input type="checkbox"/> Apply to: Right Lower Extremity (RLE), Length: Thigh High
	<b>Apply Sequential Compression Device</b> <input type="checkbox"/> Apply to Bilateral Lower Extremities <input type="checkbox"/> Apply to Right Lower Extremity (RLE) <input type="checkbox"/> Apply to Left Lower Extremity (LLE)
	<b>Apply Pedal Pump</b> <input type="checkbox"/> Apply to Bilateral Feet <input type="checkbox"/> Apply to Right Foot <input type="checkbox"/> Apply to Left Foot
<b>Medications</b>	
<b>Medication sentences are per dose. You will need to calculate a total daily dose if needed.</b>	
	VTE Prophylaxis: Trauma Dosing. For CrCl LESS than 30 mL/min, use heparin. Pharmacy will adjust enoxaparin dose based on body weight.  <b>enoxaparin (enoxaparin for weight 40 kg or GREATER)</b> <input type="checkbox"/> 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
	<b>heparin</b> <input type="checkbox"/> 5,000 units, subcut, inj, q12h <input type="checkbox"/> 5,000 units, subcut, inj, q8h
	VTE Prophylaxis: Non-Trauma Dosing  <b>enoxaparin (enoxaparin for weight 40 kg or GREATER)</b> <input type="checkbox"/> 40 mg, subcut, syringe, q24h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function <input type="checkbox"/> 30 mg, subcut, syringe, q12h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function <input type="checkbox"/> 30 mg, subcut, syringe, q24h, Prophylaxis - Non-Trauma Dosing, Pharmacy to Adjust Dose per Renal Function <input type="checkbox"/> 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
	<b>rivaroxaban</b> <input type="checkbox"/> 10 mg, PO, tab, In PM
	<b>warfarin</b> <input type="checkbox"/> 5 mg, PO, tab, In PM
	<b>aspirin</b> <input type="checkbox"/> 81 mg, PO, tab chew, Daily <input type="checkbox"/> 325 mg, PO, tab, Daily

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ORTHO REPLANTATION/FLAP POST-OP PLAN  
- Phase: VTE PROPHYLAXIS PLAN

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	<p>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</p> <p><b>fondaparinux</b></p> <p><input type="checkbox"/> 2.5 mg, subcut, syringe, q24h Prophylactic use is contraindicated in patients LESS than 50 kg or CrCl LESS than 30 mL/min</p>

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