UMC Health System

SICU ADULT HFOV PROTOCOL 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
	Respiratory
	SICU Adult High Frequency Oscillator Pro (SICU Adult High Frequency Oscillator Protocol)
	Notify RT (May decrease Tidal Volume less than 6mL/kg) ☐ May decrease Tidal Volume less than 6mL/kg
	Notify RT (DO NOT decrease Tidal Volume less than 6mL/kg) ☐ DO NOT decrease Tidal Volume less than 6mL/kg

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

Order Taken by Signature: _____ Date _____ Time _____

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