UMC Health System		Patient Label Here
SI	JRGERY BURN PLAN	
	PHYSICIA	N ORDERS
Diagnos	is	
Weight	Allergies	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific order detail box(es) where applicable.
ORDER	ORDER DETAILS	
	Patient Care	
	Vital Signs Per Unit Standards	
	Perform Neurovascular Checks	
		a2h
	Daily Weight	
	Patient Activity Up Ad Lib/Activity as Tolerated   Assist as Needed	Bedrest
	ICU Progressive Mobility Guidelines	
	***See Reference Text***	
	Ambulate Patient	
	Instruct to Turn, Cough, & Deep Breath	
	Urinary Catheter Care	
	Insert Gastric Tube INAsogastric - NG, To: Low Intermittent Suction Dobhoff Tube	□ Nasogastric - NG
	Place Device at Bedside (Place Bronchoscope at Bedside)	
	POC Blood Sugar Check	
	Monitoring	
	Required if burn is 20% or more TBSA.	
	Bladder Pressure Monitoring q4h, for 72h	
	Communication	
	Notify Provider/Primary Team of Pt Admit Upon Arrival to Floor/Unit Now	In AM
	Notify Provider of VS Parameters	
	Notify Provider (Misc) ☐ Reason: If 2 consecutive blood sugar checks are above 160 mg/dL, or order an insulin drip plan.	r one blood sugar check above 180 mg/dL, contact a provider to
	Notify Provider (Misc) T;N, Reason: Notify the provider of urine output less than 0.5 mL/kg/p	er hour.
	Notify Provider (Misc)	
	Dietary	
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UMC Health System SURGERY BURN PLAN		Patient Label Here		
		ra		
		AN ORDERS	a datail bau(aa) whana amaliachta	
ORDER	Place an "X" in the Orders column to designate orders of choice Al ORDER DETAILS	ND an "x" in the specific orde	er detail box(es) where applicable.	
ORDER	NPO Diet			
	NPO, Except Meds NPO, Except Ice Chips	NPO NPO, Except Meds, Except	pt Ice Chips	
	Oral Diet ☐ High Prot/High Cal Diet			
	IV Solutions			
	D5 1/2 NS + 20 mEq KCI/L □ IV, 75 mL/hr	□ IV, 125 mL/hr		
	□ IV, 75 mL/hr □ IV, 150 mL/hr	☐ IV, 125 mL/hr ☐ IV, 200 mL/hr		
	Fluid Resuscitation			
	****Order LR below for rate titration based on urine output****			
	LR □ IV, Titrate LR to maintain urine output of 0.5 mL/kg/hr., mL/hr, x 24 hr □ IV, For electrical burns: titrate LR to maintain a urine output of 1 mL/kg/hr, mL/hr, x 24 hr			
	Medications			
	Medication sentences are per dose. You will need to calculate a total daily dose if needed. vitamin A			
	10,000 units, PO, cap, Daily			
	ascorbic acid 500 mg, per tube, liq, BID, Oral LIQUID	500 mg, PO, tab, BID, Ora	al TABLET	
	multivitamin with minerals 15 mL, per tube, liq, Daily, Oral LIQUID	1 tab, PO, tab, Daily, Oral	TABLET	
	zinc sulfate ☐ 220 mg, per tube, liq, Daily, Oral LIQUID	220 mg, PO, cap, Daily, C	Dral CAPSULE	
	<b>docusate</b> ☐ 100 mg, per tube, liq, BID, Oral LIQUID	☐ 100 mg, PO, cap, BID, Or	al CAPSULE	
	senna ☐ 17.6 mg, per tube, liq, Nightly, [17.6 mg/10 mL] Oral LIQUID ☐ 17.2 mg, PO, tab, Nightly, Oral TABLET			
	polyethylene glycol 3350 ☐ 1 packet, PO, liq, Daily, [1 packet = 17 g] Mix in 4-8 oz of liquid			
	diphenhydrAMINE 25 mg, PO, liq, q4h, PRN itching ***If diphenhydrAMINE is contraindicated or ineffective, use hydrOXYzine IF ordered****			
	hydrOXYzine	25 mg, PO, tab, q4h, PRN	l itching, Oral TABLET	
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	UMC Health System	Patient Label Here		
SI	JRGERY BURN PLAN			
	PHYSICIA	N ORDERS		
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific order detail box(es) where applicable.		
ORDER	ORDER DETAILS			
	ondansetron 4 mg, PO, tab, q8h, PRN nausea/vomiting Tablet may be crushed if needed			
	4 mg, IVPush, soln, q8h, PRN nausea/vomiting			
	<ul> <li>chlorhexidine topical (chlorhexidine 0.12% mucous membrane liquid)</li> <li>15 mL, swish &amp; spit, mouthwash, BID, non-intubated patients apply using oral care swab</li> <li>15 mL, swish &amp; spit, mouthwash, TID, intubated patients apply using oral care swab</li> </ul>			
	Once patient is extubated, please discontinue nystatin order.			
	nystatin (nystatin 100,000 units/mL oral suspension) 5 mL, swish &swallow, liq, TID If patient is unable to swallow, swab mouth with medication. Once pa	tient is extubated, please discontinue nystatin order.		
	<ul> <li>☐ 1 mL, swish &amp;swallow, liq, TID</li> <li>If patient is unable to swallow, swab mouth with medication. Once patient is extubated, please discontinue nystatin order.</li> <li>☐ 2 mL, swish &amp;swallow, liq, TID</li> </ul>			
	If patient is unable to swallow, swab mouth with medication. Once patient is extubated, please discontinue nystatin order. 4 mL, swish &swallow, liq, TID If patient is unable to swallow, swab mouth with medication. Once patient is extubated, please discontinue nystatin order.			
	probiotic, multistrain			
	GI Prophylaxis			
	famotidine         20 mg, per tube, liq, BID, Oral LIQUID         20 mg, IVPush, inj, BID         Dilute to 2 mg/mL with NS. IV push over 2 min.			
	pantoprazole ☐ 40 mg, per tube, liq, Daily, Oral LIQUID ☐ 40 mg, IVPush, inj, Daily IVPush over 2 min. Reconstitute with 10mL NS. Stable for 2 hrs at ro	☐ 40 mg, PO, tab ec, Daily, Oral TABLET		
	sucralfate         1 g, per tube, liq, TID, ORAL LIQUID         Must be given orally or in gastric tube, not for post-pyloric feeding access         1 g, PO, liq, TID, ORAL TABLET         Must be given orally or in gastric tube, not for post-pyloric feeding access			
	Burn Care Treatment			
	emollients, topical (Aquaphor topical ointment)  1 app, topical, bulk topical, Daily, PRN burn care			
	emollients, topical (Nivea topical cream)			
	emollients, topical (Nivea topical lotion) 1 app, topical, lotion, as needed, PRN burn care			
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	PHYSICIA Place an "X" in the Orders column to designate orders of choice AN	N ORDERS D an "x" in the specific ord	er detail box(es) where applicable.
	Laboratory		
	Chromium Level, Copper Level, Cobalt Level, Manganese Level, Magne Zinc levels are required for all burns 30% or greater and all NSTI's.	sium Level, Procalcitonin Lev	vel, Selenium Level, and
	Chromium Routine, T;N		
	Chromium Routine, T;N, Every Monday		
	Cobalt Routine, T;N		
	Cobalt Cobalt Routine, T;N, Every Monday		
	Copper Level Countrie, T;N		
	Copper Level Broutine, T;N, Every Monday		
	Magnesium Level		
	Magnesium Level Boutine, T;N, Every Monday		
	Manganese Level Routine, T;N		
	Manganese Level Broutine, T;N, Every Monday		
	Procalcitonin Level		
	Procalcitonin Level Broutine, T;N, Every Monday		
	Selenium Level		
	Selenium Level Broutine, T;N, Every Monday		
	Zinc Level		
	Zinc Level Routine, T;N, Every Monday		
	Amylase Level		
	Lipase Level		
	C Reactive protein (CRP)		
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SURGERY BURN PLAN		Patient Label Here		
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	PHYSICIA	N ORDERS		
	Place an "X" in the Orders column to designate orders of choice AN			
ORDER	ORDER DETAILS			
	D Dimer HS 500			
	Fibrinogen Level			
	Prealbumin			
	Platelet Mapping (TEG)			
	TSH Routine, T;N			
	TSH □ Routine, T;N, Every Monday			
	Cortisol Random			
	Cortisol Random Broutine, T;N, Every Monday			
	Hemoglobin A1C Routine, T;N Order "Myoglobin" below for greater than 20% TBSA patients Myoglobin g4h for 72 hr			
	Diagnostic Tests			
	EKG-12 Lead			
	DX Chest Portable			
	Respiratory Respiratory Care Plan Guidelines			
	TSICU/BICU Routine Ventilator Management (TSICU/BICU Routine Ventilator Management Protocol)			
	Arterial Blood Gas			
	Additional Tests: Ca++ (Ionized Calcium)   Lactate			
	IS Instruct			
	Physical Medicine and Rehab			
	Consult MD Service: Physical Medicine and Rehabilitation(MD)			
	Wound Evaluation and Treatment by PT Bur (Wound Evaluation and	Treatment by PT Purp Wound/Skin Care Services)		
	Consult PT Mobility for Eval & Treat	Treatment by FT built would/Skin care Services)		
	Consult Speech Therapy for Eval & Treat			
	Consult Occ Therapy for Eval & Treat			
	Consults/Referrals			
	Consult MD			
	Service: Ophthalmology, Reason: Burn			
	Additional Orders			
L				
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รเ	JRGERY BURN PLAN	Pa	tient Label Here
	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	er detail box(es) where applicable.
ORDER	ORDER DETAILS		
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Physician	Signature:	Date	Time



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A	DULT BURN/WOUND PAIN AND ANXIOLYSIS PLAN	P	atient Label Here		
	JULT BURN/WOUND PAIN AND ANXIOL 1313 PLAN				
	PHYSICIA	N ORDERS			
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific or	ler 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.           Background pain/Neuropathic pain         Background pain/Neuropathic pain				
	Only choose ONE of the following: pregabalin or gabapentin				
	pregabalin ☐ 50 mg, PO, cap, BID				
	<b>gabapentin</b> ☐ 300 mg, PO, cap, q8h				
	Only choose ONE of the following: acetaminophen-codeine #3 or traMAL	Dol			
	acetaminophen-codeine (acetaminophen-codeine #3)				
	traMADol 50 mg, PO, tab, q6h				
	methadone 2.5 mg, PO, soln, q8h				
	Breakthrough pain				
	HYDROmorphone 0.25 mg, IVPush, inj, q4h, PRN pain-severe (scale 7-10)/breakthrough				
	Wound care pain control and anxiolysis				
	Anxiolysis				
	Use adjusted body weight for dose calculation in obese patients (BMI > 30)				
	ketamine				
	2.5 mg/kg, PO, inj, Daily, PRN burn care, Use adjusted body weight for Give 20 minutes prior to burn care, mix in 50 mL of orange juice	or dose calculation in obese	patients (BMI greater than 30).		
	Use the IV injection for oral use. Use adjusted body weight for dose of	alculation in obese patients	(BMI greater than 30).		
	midazolam				
	☐ 5 mg, PO, liq, Daily, PRN wound care Administer 30-45 mintues prior to wound care for anxiolysis				
	· · ·				
	midazolam ☐ 1 mg, IVPush, inj, q20min, PRN anxiety				
	Anxiety during wound care. Max dose = 4 mg for 1 wound care sessi	on			
	Analgesia				
	Only choose ONE of the following- acetaminophen-codeine #3 or traMAI	Dol			
	acetaminophen-codeine (acetaminophen-codeine #3)				
	traMADol ☐ 100 mg, PO, tab, Daily, PRN wound care				
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	OULT BURN/WOUND PAIN AND ANXIOLYSIS PLAN	ra	
	BHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN		er detail box(es) where applicable
ORDER		<u> //</u>	
-	morphine		
	30 mg, PO, liq, Daily, PRN wound care		
	<ul> <li>Idocaine (Iidocaine 2,000 mg/500 mL (IVPB for Burn Care))</li> <li>↓ 480 mg, IVPB, ivpb, q24h, PRN burn care, Infuse over 4 hr Give a 1.5 mg/kg bolus over 5 minutes 30 minutes prior to wound care prior to wound care AND 15 minutes prior to wound care. When wour continuous until wound care is completed. Discontinue drip when patients</li> </ul>	nd care is initiated start the lide	
	During Wound Care		
	morphine		
	2 mg, IVPush, inj, q15min, PRN other Pain during wound care. Max dose = 8 mg for 1 wound care session		
	HYDROmorphone □ 0.25 mg, IVPush, inj, q15min, PRN other Pain during wound care. Max dose = 1 mg for 1 wound care session		
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		N ORDERS	
00050	Place an "X" in the Orders column to designate orders of choice AN	ID an "x" in the specific orde	er detail box(es) where applicable.
ORDER	ORDER DETAILS Laboratory		
	Hematology		
	CBC □ Routine, T;N		
	CBC □ Next Day in AM, Every AM		
	CBC with Differential		
	Coagulation		
	Anti Xa Level Timed, T;1300, Every M and Th		
	Anti Xa Level Timed, T;1300, Every T and F		
	Prothrombin Time with INR		
	Prothrombin Time with INR INext Day in AM, Every AM		
	PTT		
	PTT Next Day in AM, Every AM		
	Chemistry		
	Renal Function Panel		
	Renal Function Panel Next Day in AM, Every AM		
	Basic Metabolic Panel		
	Comprehensive Metabolic Panel		
	Magnesium Level		
	Magnesium Level		
	Phosphorus Level		
	Phosphorus Level		
	CK □ Routine, T;N, q8h 48 hr		
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Order Take	n by Signature:	Date	Time
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IC	U LAB PLAN		
		N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	r detail box(es) where applicable.
ORDER	ORDER DETAILS Myoglobin		
	Routine, T;N, q8h 48 hr		
	Nutrition Labs		
	Prealbumin Routine, T;N		
	Prealbumin IN Next Day in AM, Every M and Th		
	C Reactive protein (CRP)		
	C Reactive protein (CRP) Next Day in AM, Every M and Th		
	Urine 24hr Urea Nitrogen INext Day in AM, Every Monday		
	Respiratory		
	Arterial Blood Gas (ABG with Lactate) STAT, Additional Tests: Lactate, PRN:		
	Arterial Blood Gas (ABG with Lactate) ☐ Routine, Additional Tests: Lactate, Every AM, PRN, Continue while pa bipab, or hiflow oxygen.	atient is on ventlator. D/C once	patient is no longer on vent,
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# GERIATRIC BURN/WOUND PAIN AND ANXIOLYSIS PLAN

	PHYSICIAN ORDERS		
	Place an "X" in the Orders column to designate orders of choice AN	ID an "x" in the specific orde	er detail box(es) where applicable.
ORDER	ORDER DETAILS		
	Medications		
	Medication sentences are per dose. You will need to calculate a to	tal daily dose if needed.	
	Background Pain/ Neuropathic Pain		
	Only choose ONE of the following: pregabalin or gabapentin		
	acetaminophen 500 mg, PO, tab, q6h		
	Do not exceed 4000 mg of acetaminophen per day from all sources.		
	□ 1,000 mg, PO, tab, q6h Do not exceed 4000 mg of acetaminophen per day from all sources.		
	Do not exceed 4000 mg of acetaninophen per day nom an sources.		
	<b>gabapentin</b> 100 mg, PO, cap, Daily	100 mg, per tube, liq, Dail	
	$\square$ 100 mg, PO, cap, q12h	$\square$ 100 mg, per tube, liq, q12	
	pregabalin		
	50 mg, PO, cap, BID		
	traMADol 25 mg, PO, tab, q6h		
	25 mg, PO, tab, q12h, Use for CrCl less than 30 mL/min or severe he	epatic impairment	
	Breakthrough pain		
	Choose either acetaminophen-codeine or traMADol.		
	acetaminophen-codeine (acetaminophen-codeine (Tylenol with Codeine) 120 mg-12 mg/5 mL oral liquid)		
	5 mL, PO, liq, q12h, PRN pain-moderate (scale 4-6)/breakthrough		
	Do not exceed 3000 mg of acetaminophen per day from all sources. 5 mL, per tube, liq, q12h, PRN pain-moderate (scale 4-6)/breakthrough		
	Do not exceed 3000 mg of acetaminophen per day from all sources.	J. 1	
	traMADol		
	25 mg, PO, tab, q6h, PRN pain-moderate (scale 4-6)/breakthrough		
	25 mg, per tube, tab, q6h, PRN pain-moderate (scale 4-6)/breakthrou	ıgh	
	Wound care pain control and anxiolysis		
	Anxiolysis		
	ketamine		
	□ 0.5 mg/kg, PO, inj, q24h, PRN burn care Give 20 minutes prior to burn care, mix in 30 mL of orange juice		
	Use the IV injection for oral use		
	Max dose 2.5 mg/kg. Continued on next page		
	Continued of next page		
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Order Take	n by Signature:	Date	Time
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## GERIATRIC BURN/WOUND PAIN AND ANXIOLYSIS 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				
	<ul> <li>midazolam</li> <li>☐ 1 mg, IVPush, inj, Daily, PRN burn care, To be given at the start of bu Do not give oral midazolam.</li> </ul>	rn care.			
	midazolam □ 0.5 mg, IVPush, inj, q15min, PRN burn care Not to exceed 2 mg midazolam for wound care. Do not give oral midazolam.				
	Analgesia Only choose ONE of the following- acetaminophen-codeine #3 or traMADol acetaminophen-codeine (acetaminophen-codeine (Tylenol with Codeine) 120 mg-12 mg/5 mL oral liquid) 5 mL, PO, liq, q24h, burn care Do not exceed 3000 mg of acetaminophen per day from all sources. 5 mL, per tube, liq, q24h, burn care Do not exceed 3000 mg of acetaminophen per day from all sources.				
	traMADol □ 25 mg, PO, tab, q24h, PRN burn care	25 mg, per tube, tab, q24	n, PRN burn care		
	fentaNYL         □       25 mcg, IVPush, inj, q30min, PRN burn care, To be given a the start of burn care         To be given at the start of burn care.         Repeat if needed after 30 min.         Do not exceed 100 mcg fentanyl during burn care.         50 mcg, IVPush, inj, q30min, PRN burn care, To be given at the start of burn care         To be given at the start of burn care.         Repeat if needed after 30 min.         Do not exceed 100 mcg fentanyl during burn care.         Repeat if needed after 30 min.         Do not exceed 100 mcg fentanyl during burn care.				
	Lidocaine NOT to be used with any cardiac history or electrolyte abnormality. Decrease dose by 50% with eGFR less than 30 mL/min. <b>lidocaine (lidocaine 2,000 mg/500 mL (IVPB for Burn Care))</b> 480 mg, IVPB, ivpb, q24h, PRN burn care, Infuse over 4 hr Give a 1.5 mg/kg bolus over 5 minutes 30 minutes prior to wound care. Then give a 0.5 mg/kg bolus over 5 minutes 20 minutes prior to wound care AND 15 minutes prior to wound care. When wound care is initiated start the lidocaine drip at 2 mg/min continuous until wound care is completed. Discontinue drip when patient returns to room.				
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Order Take	n by Signature:	Date	Time		
Physician S	Physician Signature: Date Time				

#### **BURN FLUID RESUSCITATION PLAN**

	PHYSICIAN	ORDERS		
	Place an "X" in the Orders column to designate orders of choice AND	an "x" in the specific ord	er detail box(es) where applicable.	
ORDER	ORDER DETAILS			
	Stage 1 Resuscitation			
	The baseline resuscitation rate is 2 mL/kg/TBSA for adults			
	The baseline resuscitation rate is 3 mL/kg/TBSA for children under 14 (see DPP 571.10)			
	The baseline resuscitation rate is 4 mL/kg/TBSA for all electrical injuries			
	Lactated Ringers (LR) is used for baseline resuscitation. Start resuscitation at the calculated hourly rate for the first eight hours according to the consensus formula.			
	If LR reaches rate greater than 600 mL/hr and urine output is less than target or if there are two MAPs less than 60 in the hour and urine output is less than target, notify provider and move to Stage 2 resuscitation as ordered			
	Stage 2 Resuscitation			
	Stage 3 Resuscitation			
	Continue LR with same instructions as stage 1 resuscitation			
	Provider may consider changing to FFP drip at 100 mL/hr.			
	Stage 4 Resuscitation			
	Patient Care			
	Strict Intake and Output T;N, q1h, Obtain urine output hourly			
	Strict Intake and Output			
	Strict Intake and Output T;N, STAT, q1h, If urine output is meeting target, return to stage 1 resuscitation, continuing albumin drips			
	Communication			
	Notify Nurse (DO NOT USE FOR MEDS) T;N, If urine output is under target, increase LR rate by 25%			
	Notify Nurse (DO NOT USE FOR MEDS)         T;N, If urine output is over target, decrease LR rate by 25%			
	Notify Nurse (DO NOT USE FOR MEDS) T;N, Once FFP is completed continue to monitor blood pressure and urine output for one full hour. During this time continue titrating LR as directed in stage 1.			
	Notify Nurse (DO NOT USE FOR MEDS)			
	Notify Provider (Misc) (Notify Provider of Results) T;N, Reason: If two MAP values less than 60 and urine output is still less than target or LR is still greater than 600 mL/hr and urine output is less than target, notify provider and move to stage 3 resuscitation.			
	Notify Nurse (DO NOT USE FOR MEDS) T;N, Obtain order for 500 mL of 5% albumin or two units FFP			
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Order Take	en by Signature:	Date	Time	
Physician S	Physician Signature: Date Time			



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#### **BURN FLUID RESUSCITATION PLAN**

	PHYSICI	AN ORDERS		
	Place an "X" in the Orders column to designate orders of choice Al	ND an "x" in the specific ord	er detail box(es) where applicable.	
ORDER	ORDER DETAILS			
	<b>Notify Nurse (DO NOT USE FOR MEDS)</b> T;N, Obtain order to increase 5% albumin drip rate to 100 mL/hr			
	Notify Provider (Misc) T;N, Reason: If two MAP values less than 60 and urine output is still less than target or LR is still at greater than 600 mL/hr and urine output is less than target, notify provider to consider additional FFP and vasopressors			
	Notify Nurse (DO NOT USE FOR MEDS) T;N, Continue aggressive crystalloid and colloid support as ordered by provider.			
	Notify Nurse (DO NOT USE FOR MEDS) T;N, As necessary, obtain order for norepinephrine to begin at 3 mcg/min and titrate to MAP of 65.			
	Notify Nurse (DO NOT USE FOR MEDS)			
	IV Solutions			
	LR IV, mL/hr Lactated Ringers (LR) is used for baseline resuscitation. Start resusc hours according to the consensus formula.	itation at the calculated hourly	rate for the first eight	
	norepinephrine 4 mg/250 mL NS - Titratab (norepinephrine 4 mg/250 mL NS - Titratable) 250 mL final vol, IV, Max dose: 60 mcg/min, Primary Titration Goal Maintain MAP Greater Than 65 Start at rate:mcg/min			
	vasopressin 20 units/50 mL NS - Titratab (vasopressin 20 units/50 m 50 mL final vol, IV, Maintain MAP Greater Than 65	nL NS - Titratable)	units/min	
	Medications Medication sentences are per dose. You will need to calculate a to	tal daily dose if needed		
	albumin human (albumin human 5%)	······································		
	Laboratory			
	BB Plasma for pts 25 kg or GREATER			
	BB Plasma for pts 25 kg or GREATER			
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Order Take	n by Signature:	Date	Time	
Physician	ignature:	Date	Time	



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#### ELECTROLYTE MED PLAN - ICU ONLY

	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)				
	Check below to select the Aggressive Potassium, phosphate, and mag May then uncheck any replacement orders not wanted.	inesium.			
	Communication Order				
	Medications				
	Medication sentences are per dose. You will need to calculate a t	-			
	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 orde	rs - Aggressive or Non-Aggre	essive		
	AGGRESSIVE IV POTASSIUM REPLACEMENT - Replacement dose	s for potassium levels 3.6 ml	Mol/L to 3.9 mMol/L:		
	<ul> <li>potassium chloride</li> <li>20 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 2 hr, K+ level 3.6 - 3.9 mMol/L</li> <li>If K+ level 3.6 - 3.9 mMol/L - Administer 20 mEq KCl ivpb</li> <li>Repeat serum potassium level 2 hours after total replacement is completed.</li> <li>Notify provider and check magnesium level if potassium deficiency does not correct after two replacement attempts.</li> </ul>				
	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:		
	<ul> <li>potassium chloride</li> <li>40 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 4 hr, If K+ level 3.1 - 3.5 mMol/L</li> <li>If K+ level 3.1 - 3.5 mMol/L - Administer 40 mEq KCl ivpb</li> <li>Repeat serum potassium level 2 hours after total replacement is completed.</li> <li>Notify provider and check magnesium level if potassium deficiency does not correct after two replacement attempts.</li> <li>Continued on next page</li> </ul>				
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## ELECTROLYTE MED PLAN - ICU ONLY

	PHYSICIAN ORDERS				
	Place an "X" in the Orders column to designate orders of choice Al	ND an "x" in the specific orde	er 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 KCI 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.				
	<ul> <li>sodium phosphate</li> <li>30 mmol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over 4 hr, For serum phosphorus level 1.0 - 3.0 mg/dL.</li> <li>If Phos level 1-3.0 mg/dL AND sodium level less than 145 mMol/L - Administer 30 mMol sodium phosphate.</li> <li>Repeat serum phosphorus level 6 hours after infusion completed.</li> </ul>				
	<ul> <li>sodium phosphate</li> <li>45 mMol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over 6 hr, For serum phosphorus level LESS than 1 mg/dL.</li> <li>If Phos level less than 1 mg/dL AND sodium level less than 145 mMol/L - Administer 45 mMol sodium phosphate and notify provider.</li> <li>Repeat serum phosphate level 6 hours after infusion completed.</li> </ul>				
	NON-AGGRESSIVE IV SODIUM PHOSPHATE REPLACEMENT: Select both sodium phosphate orders to replace phos levels LESS than or				
	equal to 2.5 mg/dL				
	<ul> <li>sodium phosphate</li> <li>30 mMol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over 4 hr, For serum phosphorus level 1-2.5 mg/dL.</li> <li>If Phos level 1 - 2.5 mg/dL AND sodium level less than 145 mMol/L - Administer 30 mMol sodium phosphate.</li> <li>Repeat serum phosphorus level 6 hours after infusion completed.</li> </ul>				
	<ul> <li>sodium phosphate</li> <li>45 mMol, IVPB, ivpb, as needed, PRN hypophosphatemia, Infuse over 6 hr, For serum phosphorus level LESS than 1 mg/dL.</li> <li>If Phos level less than 1 mg/dL AND sodium level less than 145 mMol/L - Administer 45 mMol sodium phosphate and notify provider.</li> <li>Repeat serum phosphate level 6 hours after infusion completed.</li> </ul>				
	IV MAGNESIUM REPLACEMENT:				
	<ul> <li>magnesium sulfate</li> <li>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.</li> <li>Continued on next page</li> </ul>				
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## ELECTROLYTE MED PLAN - ICU ONLY

	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			
	· · ·			
	<ul> <li>magnesium sulfate</li> <li>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.</li> <li>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.</li> <li>Repeat serum magnesium level 2 hours after the infusion is completed.</li> </ul>			
	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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IC	U SEDATION AND PAIN MED PLAN		
	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific order detail box(	es) where applicable.
ORDER	ORDER DETAILS		
	Patient Care Utilize the Richmond Agitation Sedation (Utilize the Richmond Agitat   ***See Reference Text***	ion Sedation Scale)	
	Perform Awakening Trial Daily ***See Reference Text***		
	ICU Pain/Agitation/Delirium Reference		
	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 tot	al daily dose if needed	
	***SEDATIVE MEDICATIONS SHOULD ONLY BE GIVEN AFTER PAIN	-	
	If delirium noted give:		
	<ul> <li>haloperidol</li> <li>☐ 5 mg, IVPush, inj, q2h, PRN agitation</li> <li>Notify physician if more than 100 mg is administered over 48 hours.</li> </ul>		
	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		
	<b>propofol</b> 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***	
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ICU SEDATION AND PAIN MED PLAN			
00050	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	r 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 a 5 mg/kg, IVPush, inj, ONE TIME	re hypertensive with a blood p	pressure GREATER than 180/90.
	Infuse slowly with inotropes amiodarone or milrinone or patients that a	re hypertensive with a blood p	pressure GREATER than 180/90.
	6 mg/kg, IVPush, inj, ONE TIME Infuse slowly with inotropes amiodarone or milrinone or patients that a	ro hyportonsivo with a blood r	Procesure CREATER than 180/00
			JESSUIE GREATER MAIL 160/90.
	Intermittent Dose		
	Pain Meds		
	<b>morphine</b> 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 hou 4 mg, IVPush, inj, q2h, PRN pain-with sedation (scale 4-10)	irs to a maximum of 4 mg.	
	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	6 H H+++	
	***Sedative medications should only be given after pain is adequately	controlled***	
	Continuous Infusion		
	Pain Meds		
	morphine 100 mg/100 mL NS - Titratable		
	□ 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		
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	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	er 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 ☐ 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***	mg/100 mL NS - Titratable)	
	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     mg, Bolus Indication: for sedation     Final concentration= 10 mg/mL (10,000 mcg/mL).     ***Sedative medications should only be given after pain is adequately     Start at rate:mcg/kg/min		req: q2h, Bolus 4-hour Limit: 100
	***Midazolam should NOT be used in patients with creatinine greater that	n 2 and/or for more than 72 ho	DUIS***
	<ul> <li>midazolam 100 mg/100 mL NS - Titratable</li> <li>Start at rate:mg/hr</li> <li>IV, Max titration: 1 mg/hr every 5 minutes, Max dose: 8 mg/hr</li> <li>Final concentration = 1 mg/mL (1,000 mcg/mL).</li> <li>***Do NOT initiate infusion unless intermittent dosing has failed***</li> <li>***Sedative medications should only be given after pain is adequately</li> </ul>	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***	
	<ul> <li>dexmedetomidine 400 mcg/100 mL - Titrata (dexmedetomidine 400 m</li> <li>IV, Max titration: 0.1 mcg/kg/hr every 30 minutes, Max dose: 1.5 mcg/ Final concentration = 4 mcg/mL.</li> <li>***Sedative medications should only be given after pain is adequately Continued on next page</li> </ul>	kg/hr	
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ICU SEDATION AND PAIN MED PLAN			
	PHYSICIA		
	Place an "X" in the Orders column to designate orders of choice AN	ID an "x" in the specific orde	r 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         Infuse slowly with inotropes amiodarone or milrinone or in patients that		
	Laboratory		
	***If patient remains on a propofol infusion after 48 hours monitor Triglyo until propofol discontinued.*** Triglycerides	cerides now and every 3 days	
	Notify Provider (Misc) (Notify Provider of Results)		
	Reason: Triglyceride Level greater than 400 mg/dL		
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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         Patient Caro       Insulin Drip Protocol         Image: Insulin Drip Protocol       Image: Insulin SubQ.         Image: Insulin SubQ. IV or in TPN, feedings are started, stopped, or changed, or if other physicans turn off drip for any reason.         Image: Insulin SubQ. IV or in TPN, feedings are started, stopped, or changed, or if other physicans turn off drip for any reason.         Image: Insulin SubQ EFOR MEDS       Image: Insulin SubQ EFOR MEDS         Image: Insulin Subco Serum Blood Glucose if Accuchede is less than 40 mg/dL or greater than
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 Caro       Insulin Drip Protocol         Image: Insulin Drip Protocol       Image: Insulin SubQ.         Image: Insulin SubQ. IV or in TPN, feedings are started, stopped, or changed, or if other physicans turn off drip for any reason.         Image: Insulin SubQ. IV or in TPN, feedings are started, stopped, or changed, or if other physicans turn off drip for any reason.         Image: Insulin SubQ EFOR MEDS       Image: Insulin SubQ EFOR MEDS         Image: Insulin Subco Serum Blood Glucose if Accuchede is less than 40 mg/dL or greater than
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 Caro       Insulin Drip Protocol         Image: Insulin Drip Protocol       Image: Insulin SubQ.         Image: Insulin SubQ. IV or in TPN, feedings are started, stopped, or changed, or if other physicans turn off drip for any reason.         Image: Insulin SubQ. IV or in TPN, feedings are started, stopped, or changed, or if other physicans turn off drip for any reason.         Image: Insulin SubQ EFOR MEDS       Image: Insulin SubQ EFOR MEDS         Image: Insulin Subco Serum Blood Glucose if Accuchede is less than 40 mg/dL or greater than
ORDER       ORDER DETAILS         Patient Caro       Insulin Drip Protocol         Image: Insulin Drip Protocol       Image: Insulin SubQ, IV, or In TPN, feedings are started, stopped, or changed, or if other physicans turn off drip for any reason.         Image: Insulin Drip Protocol       Image: Insulin SubQ, IV, or In TPN, feedings are started, stopped, or changed, or if other physicans turn off drip for any reason.         Image: Insulin Drip Protocol       Image: Insulin SubQ, IV, or In TPN, feedings are started, stopped, or changed, or if other physicans         Image: Insulin Drip Dromain:       Image: Insulin SubQ, IV, or In TPN, feedings are started, stopped, or changed, or if other physicans         Image: Insulin Drip Dromain:       Image: Insulin Dromain:       Image: Insulin Dromain:
Pationt Garo         Insulin Drip Protocol         Insulin Drip Protocol         If See Reference Text***         LOW Target Blood Glucose         120 mg/dL         HIGH Target Blood Glucose         Image: The set of
Insulin Drip Protocol         Image: Selectence Text***         LOW Target Blood Glucose         120 mg/dL         HIGH Target Blood Glucose         140 mg/dL         HIGH Target Blood Glucose         140 mg/dL         Bio 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         Medications methences are per dose. You will need to calculate a total daily dose if needed.         Insulin R 100 units/100 mL NS         IV         Insulin R 100 units/100 mL NS      <
120 mg/dL       140 mg/dL         HiGH Target Blood Glucose       160 mg/dL         180 mg/dL       160 mg/dL         Communication       160 mg/dL         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: 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 tother 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         IV       Insulin Drip Formula: (BG - 60) x 0.03 = number of UNITS insulin/hour         BG = Current Blood Glucose       0.03 = number of UNITS insulin/hour         BG = Current Blood Glucose       0.03 = number of UNITS insulin/hour         BG = Current Blood Glucose
I 40 mg/dL       I 60 mg/dL         I 80 mg/dL       I 60 mg/dL         POC Blood Sugar Check       POC Blood Sugar Check         q1h, by fingerstick, CVL, or arterial line. DO NOT alternate sites without Physician approval.         Communication         Notify Provider (Misc)         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 Vorse (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:
□       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       Medications         Medications       Medication sentences are per dose. You will need to calculate a total daily dose if needed.         □       Insulin R 100 units/100 mL NS         □       V         □       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
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 Drip Formula: (BG - 60) x 0.03 = number of UNITS insulin/hour         BG = Current Blood Glucose         0.03 = "multiplier"         Start at rate:
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:
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
□       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         □
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
Medication sentences are per dose. You will need to calculate a total daily dose if needed.         insulin R 100 units/100 mL NS         IV         INV         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
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
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
BG = Current Blood Glucose 0.03 = "multiplier" Start at rate:units/hr
0.03 = "multiplier"
Start at rate:units/hr
<ul> <li>25 g, IVPush, syringe, as needed, PRN low blood sugar</li> <li>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.</li> <li>Continued on next page</li> </ul>
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INSULIN DRIP PLAN NON DKA		Pa	atient Label Here
	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific ord	er detail box(es) where applicable.
ORDER	ORDER DETAILS		
	To determine the insulin glargine (Lantus) dose, average the last 8 hours Multiply this times 20.	of the insulin drip to units pe	r hour.
	***If insulin glargine (Lantus) dose is greater than 60 units, the dose show One injection should not be more than 60 units.***	ıld be split in half and given E	BID.
	insulin glargine ☐ units, subcut, inj, Daily Administer the initial dose of Lantus 2 hours PRIOR to discontinuing the	ne insulin drip. Dose to be re	assessed by physician every
	24 hours. □ units, subcut, inj, BID	·	
	Administer the initial dose of Lantus 2 hours PRIOR to discontinuing the 24 hours.	ne insulin drip. Dose to be re	assessed by physician every
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P(	DTASSIUM CHLORIDE REPLACEMENT PLAN		
	PHYSICIA		
	Place an "X" in the Orders column to designate orders of choice AN		r detail box(es) where applicable
ORDER			
OKDEK	Patient Care		
	Potassium Replacement Guidelines T;N, See Reference Text		
	Medications		
	Medication sentences are per dose. You will need to calculate a tot	al daily dose if needed.	
	ORAL POTASSIUM REPLACEMENT		
	potassium chloride		
	40 mEq, PO, tab sa, as needed, PRN hypokalemia Use oral replacement if patient is asymptomatic and able to take ORA	I supplementation If contrain	ndicated give IV notassium
	replacement if ordered.		
	If K+ level less than 3.1 mMol/L -Contact provider immediately as IV r	eplacement may be necessary	1.
	If K+ level 3.1 - 3.5 mMol/L - Administer 40 mEq KCl oral. May give e		
	if needed.		
	Repeat potassium level with next day labs.		
	IV POTASSIUM REPLACEMENT		
	potassium chloride		
	40 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 4 hr, 1	f 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 comp	pleted.	
	potassium chloride		
	60 mEq, IVPB, ivpb, as needed, PRN hypokalemia, Infuse over 6 hr, I	K+ level less than 3.1 mMol/L	
	If K+ level less than 3.1 mMol/L -Administer 60 mEq KCl ivpb, and col	ntact provider	
	Repeat serum potassium level 2 hours after total replacement is comp	pleted.	
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00050	Place an "X" in the Orders column to designate orders of choice AN ORDER DETAILS	D an "x" in the specific or	der detail box(es) where applicable.
ORDER	Patient Care		
	POC Blood Sugar Check		
	Per Sliding Scale Insulin Frequency		
	AC & HS 3 days	TID q12h	
		<b>1</b> q6h 24 hr	
	q4h	•	
	Sliding Scale Insulin Aspart Guidelines		
	Medications		
	Medication sentences are per dose. You will need to calculate a tot	al daily dose if needed.	
	insulin aspart (Low Dose Insulin Aspart Sliding Scale)		
	0-10 units, subcut, inj, AC & nightly, PRN glucose levels - see parame Low Dose Insulin Aspart Sliding Scale	ters	
	If blood glucose is less than 70 mg/dL and patient is symptomatic, init	ate hypoglycemia guideline	s 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 alwages is greater than 400 mg/dL administer 10 units subout	notify provider and repeat	POC blood sugger shock in 00
	If blood glucose is greater than 400 mg/dL administer 10 units subcut, minutes. Continue to repeat 10 units subcut and POC blood sugar che		
	dL. Once blood sugar is less than 300 mg/dL, repeat POC blood sugar		
	insulin aspart sliding scale.		
	L 0-10 units, subcut, inj, BID, PRN glucose levels - see parameters Low Dose Insulin Aspart Sliding Scale		
	If blood glucose is less than 70 mg/dL and patient is symptomatic, init	ate hypoglycemia guideline	s 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,		
	minutes. Continue to repeat 10 units subcut and POC blood sugar che dL. Once blood sugar is less than 300 mg/dL, repeat POC blood sugar		
	insulin aspart sliding scale.		ie normal i e e bloed sugar oncok and
	Continued on next page		
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## SLIDING SCALE INSULIN ASPART 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
	<ul> <li>0-10 units, subcut, inj, TID, PRN glucose levels - see parameters</li> <li>Low Dose Insulin Aspart Sliding Scale</li> <li>If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider.</li> </ul>
	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 90 minutes. Continue to repeat 10 units subcut and POC blood sugar checks every 90 minutes 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 aspart sliding scale. 0-10 units, subcut, inj, q6h, PRN glucose levels - see parameters Low Dose Insulin Aspart 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 90 minutes. Continue to repeat 10 units subcut and POC blood sugar checks every 90 minutes 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 aspart sliding scale. 0-10 units, subcut, inj, q4h, PRN glucose levels - see parameters Low Dose Insulin Aspart 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 90 minutes. Continue to repeat 10 units subcut and POC blood sugar checks every 90 minutes 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 aspart sliding scale. Continued on next page
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Physician S	Signature: Date Time



UMC Health System SLIDING SCALE INSULIN ASPART PLAN		Р	atient Label Here
	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orc	ler detail box(es) where applicable.
ORDER	ORDER DETAILS		
Insulin aspart (Moderate Dose Insulin Aspart Silding Scale)         □ 0.12 units, subcut, inj, AC & injthily, PKN glucose levels - see parameters         Moderate Dose Insulin Aspart Silding Scale         If blood glucose is less than 70mg/dL, and patient is symptomatic, initiate hypoglycemia guidelines and notify provider.         70-150 mg/dL - 2 units subcut         201-250 mg/dL - 10 units subcut         201-250 mg/dL - 10 units subcut         201-250 mg/dL - 10 units subcut         201-260 mg/dL - 10 units subcut         201-27 Units, subcut         301-360 mg/dL - 00 units         11 Units, subcut         21 Units, subcut         221 Units, subcut, inj, BID, PKN glucose levels - see parameters         Moderate Dose Insulin Aspart Silding Scale         11 blood glucose is greater than 400 mg/dL, administer 12 units subcut, notify provider, and repeat POC blood sugar check in 90         251-300 mg/dL - 0 units         151-200 mg/dL - 10 units subcut         251-300 mg/dL - 10 units su		POC blood sugar check in 90 blood glucose is less than 300 mg/ me normal POC blood sugar check and and notify provider. POC blood sugar check in 90 blood glucose is less than 300 mg/ me normal POC blood sugar check and and notify provider.	
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## SLIDING SCALE INSULIN ASPART PLAN

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ORDER	ORDER DETAILS	of choice AND an x in the specific of	der detail box(es) where applicable.
	0.12 units, subcut, inj, q6h, PRN glucose levels - see p	arameters	
	Moderate Dose Insulin Aspart Sliding Scale If blood glucose is less than 70mg/dL and patient is syr		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 minutes. Continue to repeat 10 units subcut and POC to dL. Once blood sugar is less than 300 mg/dL, repeate insulin aspart sliding scale.	blood sugar checks every 90 minutes until l POC blood sugar in 4 hours and then resu	blood glucose is less than 300 mg/
	Moderate Dose Insulin Aspart Sliding Scale If blood glucose is less than 70mg/dL and patient is syr	nptomatic, 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 minutes. Continue to repeat 10 units subcut and POC t dL. Once blood sugar is less than 300 mg/dL, repeate insulin aspart sliding scale.	blood sugar checks every 90 minutes until l	blood glucose is less than 300 mg/
	insulin aspart (High Dose Insulin Aspart Sliding Scale) ☐ 0-14 units, subcut, inj, AC & nightly, PRN glucose level High Dose Insulin Aspart Sliding Scale If blood glucose is less than 70 mg/dL and patient is sy	s - see parameters	s 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 400mg/dL, administer 1 minutes. Continue to repeat 10 units subcut and POC t dL. Once blood sugar is less than 300 mg/dL, repeat F insulin aspart sliding scale.	blood sugar checks every 90 minutes until l	blood glucose is less than 300 mg/
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## SLIDING SCALE INSULIN ASPART 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
	<ul> <li>0-14 units, subcut, inj, BID, PRN glucose levels - see parameters</li> <li>High Dose Insulin Aspart Sliding Scale</li> <li>If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider.</li> </ul>
	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 400mg/dL, administer 14 units subcut, notify provider, and repeat POC blood sugar check in 90 minutes. Continue to repeat 10 units subcut and POC blood sugar checks every 90 minutes 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 aspart sliding scale. 0-14 units, subcut, inj, TID, PRN glucose levels - see parameters High Dose Insulin Aspart 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 400mg/dL, administer 14 units subcut, notify provider, and repeat POC blood sugar check in 90 minutes. Continue to repeat 10 units subcut and POC blood sugar checks every 90 minutes 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 aspart sliding scale. 0-14 units, subcut, inj, q6h, PRN glucose levels - see parameters High Dose Insulin Aspart 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 400mg/dL, administer 14 units subcut, notify provider, and repeat POC blood sugar check in 90 minutes. Continue to repeat 10 units subcut and POC blood sugar checks every 90 minutes 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 aspart sliding scale. Continued on next page
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## SLIDING SCALE INSULIN ASPART PLAN

	PHYSICIAN O	RDERS		
	Place an "X" in the Orders column to designate orders of choice AND a	n "x" in the specific orde	er detail box(es) where applicable.	
ORDER	ORDER DETAILS			
	0-14 units, subcut, inj, q4h, PRN glucose levels - see parameters High Dose Insulin Aspart 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 400mg/dL, administer 14 units subcut, not minutes. Continue to repeat 10 units subcut and POC blood sugar checks dL. ONce blood sugar is less than 300 mg/dL, repeat POC blood sugar ir insulin aspart sliding scale.	every 90 minutes until bl	ood glucose is less than 300 mg/	
	insulin aspart (Blank Insulin Aspart Sliding Scale) See Comments, subcut, inj, PRN glucose levels - see parameters If blood glucose is less than mg/dL, initiate hypoglycemia guidelines a	and notify provider.		
	70-150 mg/dL units subcut         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 greater than 400 mg/dL, administer units subcut, noti minutes. Continue to repeat units subcut and POC blood sugar check dL. Once blood sugar is less than 300 mg/dL, repeat POC blood sugar in insulin aspart sliding scale.	s every 90 minutes until b	blood glucose is less than 300 mg/	
	HYPOglycemia Guidelines			
	HYPOglycemia Guidelines			
	<ul> <li>glucose</li> <li>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 able to swallow. See hypoglycemia Guidelines.</li> <li>Continued on next page</li> </ul>	is less than 70 mg/dL and	I patient is symptomatic and	
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SLIDING SCALE INSULIN ASPART PLAN		Pa	tient Label Here
	PHYSICIA	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	er detail box(es) where applicable.
ORDER	ORDER DETAILS		
	<ul> <li>glucose (D50)</li> <li>25 g, IVPush, syringe, as needed, PRN glucose levels - see parameter</li> <li>Use if blood glucose is less than 70 mg/dL and patient is symtpomatic</li> <li>AND has IV access. See hypoglycemia guidelines.</li> </ul>	ers and cannot swallow OR if pa	tient has altered mental status
	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 has NO IV access. See hypoglycemia guidelines.	and cannot swallow OR if pa	tient has altered mental status
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UMC Health System SLIDING SCALE INSULIN REGULAR PLAN		Patient Label Here	
		N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific or	ter detail box(es) where applicable.
ORDER	ORDER DETAILS Patient Care		
	POC Blood Sugar Check		
	Per Sliding Scale Insulin Frequency	AC & HS	
	AC & HS 3 days	TID q12h	
		$\square$ q6h 24 hr	
	☐ q4h		
	Sliding Scale Insulin Regular Guidelines  Follow SSI Regular Reference Text		
	Medications		
	Medication sentences are per dose. You will need to calculate a tot	al daily dose if needed.	
	insulin regular (Low Dose Insulin Regular Sliding Scale)	tors	
	Low Dose Insulin Regular Sliding Scale		
	If blood glucose is less than 70 mg/dL and patient is symptomatic, init	iate hypoglycemia guidelines	s 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, init	iate hypoglycemia guidelines	s 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		
	hours. Continue to repeat 10 units subcut and POC blood sugar check Once the blood sugar is less than 300 mg/dL, repeat POC blood sugar		
	insutlin regular sliding scale. Continued on next page		
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## SLIDING SCALE INSULIN REGULAR PLAN

	PHYSICIAI	N ORDERS	
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific orde	er detail box(es) where applicable.
ORDER	ORDER DETAILS		
	-	ate hypoglycemia guidelines a , notify provider, and repeat P is every 2 hours until blood gl r in 4 hours and then resume ate hypoglycemia guidelines a , notify provider, and repeat P is every 2 hours until blood gl r in 4 hours and then resume ate hypoglycemia guidelines a ate hypoglycemia guidelines a	and notify provider. POC blood sugar check in 2 ucose is less than 300 mg/dL. normal POC blood sugar check and and notify provider. POC blood sugar check in 2 ucose is less than 300 mg/dL. normal POC blood sugar check and and notify provider.
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SL	LIDING SCALE INSULIN REGULAR PLAN			
	PHYSICIA	N ORDERS		
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific or	der 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 parame Moderate Dose Insulin Regular Sliding Scale If blood glucose is less than 70 mg/dL and patient is symptomatic, init		s 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			
	<ul> <li>351-400 mg/dL - 10 units subcut</li> <li>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.</li> <li>0-12 units, subcut, inj, BID, PRN glucose levels - see parameters Moderate Dose Insulin Regular Sliding Scale</li> <li>If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider.</li> </ul>			
	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.    O-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 subcur hours. Continue to repeat 10 units subcut and POC blood sugar che Once blood sugar is less than 300 mg/dl, repeat POC blood sugar in 4 insutlin regular scale. Continued on next page	cks every 2 hours until blood	I glucose is less than 300 mg/dL.	
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## 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
	<ul> <li>0-12 units, subcut, inj, q6h, PRN glucose levels - see parameters</li> <li>Moderate Dose Insulin Regular Sliding Scale</li> <li>If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider.</li> </ul>
	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
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Physician	Signature: Date Time



## SLIDING SCALE INSULIN REGULAR PLAN

	PHYSICIAN ORDE	RS	
	Place an "X" in the Orders column to designate orders of choice AND an "x"	in the specific ord	er detail box(es) where applicable.
ORDER	R ORDER DETAILS		
	<ul> <li>0-14 units, subcut, inj, BID, PRN glucose levels - see parameters</li> <li>High Dose Insulin Regular Sliding Scale</li> <li>If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider.</li> </ul>		
	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 p hours. Continue to repeat 10 units subcut and POC blood sugar checks every 2 Once blood sugar is less than 300 mg/dL, repeat POC blood sugar in 4 hours a 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 hypo	2 hours until blood g and then resume nor	lucose is less than 300 mg/dL. mal POC blood sugar check and
	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		
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Physician S	an Signature: D	ate	Time



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## 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			
	<ul> <li>0-14 units, subcut, inj, q4h, PRN glucose levels - see parameters</li> <li>High Dose Insulin Regular Sliding Scale</li> <li>If blood glucose is less than 70 mg/dL and patient is symptomatic, initiate hypoglycemia guidelines and notify provider.</li> </ul>			
	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 thanmg/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			
	<ul> <li>glucose</li> <li>☐ 15 g, PO, gel, as needed, PRN glucose levels - see parameters</li> <li>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.</li> <li>Continued on next page</li> </ul>			
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	UMC Health System	_		
SLIDING SCALE INSULIN REGULAR PLAN		Pa	itient Label Here	
	PHYSICIA	N ORDERS		
	Place an "X" in the Orders column to designate orders of choice AN	D an "x" in the specific ord	er detail box(es) where applicable.	
ORDER	ORDER DETAILS			
	<ul> <li>glucose (D50)</li> <li>25 g, IVPush, syringe, as needed, PRN glucose levels - see parameter</li> <li>Use if blood glucose is less than 70 mg/dL and patient is symptomatic</li> <li>AND has IV access. See hypoglycemia guidelines.</li> </ul>	ers and cannot swallow OR if pa	tient has altered mental status	
	<ul> <li>glucagon</li> <li>1 mg, IM, inj, as needed, PRN glucose levels - see parameters</li> <li>Use if blood glucose is less than 70 mg/dL and patient is symptomatic</li> <li>AND has NO IV access. See hypoglycemia guidelines.</li> </ul>	and cannot swallow OR if pa	tient has altered mental status	
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Physician	Physician Signature:			



UMC Health System		Patient Label Here			
VTE PROPHYLAXIS PLAN					
	PHYSICIA	IN 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				
	***If VTE Pharmacologic Prophylaxis not given, choose the Contraindications for VTE below and complete reason contraindi cated***				
	Contraindications VTE	<b>—</b> ———————————————————————————————————			
	☐ Active/high risk for bleeding ☐ Patient or caregiver refused	<ul> <li>Treatment not indicated</li> <li>Other anticoagulant ordered</li> </ul>	ed		
	Anticipated procedure within 24 hours	Intolerance to all VTE che			
	Apply Elastic Stockings				
	Apply to: Bilateral Lower Extremities, Length: Knee High	Apply to: Left Lower Extrem	mity (LLE), Length: Knee High		
	Apply to: Right Lower Extremity (RLE), Length: Knee High Apply to: Left Lower Extremity (LLE), Length: Thigh High		Extremities, Length: Thigh High emity (RLE), Length: Thigh High		
	Apply Sequential Compression Device				
	Apply to Bilateral Lower Extremities	Apply to Left Lower Extrem	nity (LLE)		
	Apply to Right Lower Extremity (RLE)				
	Medications				
	Medication sentences are per dose. You will need to calculate a tot		anavanarin daga bagad		
	VTE Prophylaxis: Trauma Dosing. For CrCI 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, q8h, Prophylaxis - Trauma Dosing				
	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, Pha	armacy to Adjust Dose per Ren	al 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				
	heparin □ 5,000 units, subcut, inj, q12h	5,000 units, subcut, inj, q8	h		
	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 CrCI LESS than 30 mL/min				
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Order Taken by Signature:		Date	Time		
Physician	Signature:	Date	Time		



UMC Health System		D	atient Label Here		
VTE PROPHYLAXIS PLAN					
	DHYSICIA	N ORDERS			
	Place an "X" in the Orders column to designate orders of choice AN		er detail box(es) where applicable		
ORDER					
	fondaparinux ☐ 2.5 mg, subcut, syringe, q24h Prophylactic use is contraindicated in patients LESS than 50 kg or Cr0	CI LESS than 30 mL/min			
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Order Take	n by Signature:	Date	Time		
Physician Signature:					

