

General

Isolation

Airborne isolation status

| | | | |
|---|---|--|---|
| <input type="checkbox"/> Airborne isolation status | Details | <u>Defaults</u> | <u>Available Buttons</u> |
| <input type="checkbox"/> Mycobacterium tuberculosis by PCR - If you suspect Tuberculosis, please order this test for rapid diagnostics. | Frequency: Specimen type: Specimen source: Comments: Phase of Care: | <u>Once</u> <u>Sputum</u> | [Once] [STAT] [AM Draw] [Timed] [Sputum] [Tracheal aspirate] [Induced] [Expectorated] [Not otherwise specified] |

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|---|---------|------------------------|---------------------------------|
| <input type="checkbox"/> Contact isolation status | Details | <u>Defaults</u> | <u>Available Buttons</u> |
|---|---------|------------------------|---------------------------------|

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|---|---------|------------------------|---------------------------------|
| <input type="checkbox"/> Droplet isolation status | Details | <u>Defaults</u> | <u>Available Buttons</u> |
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|---|---------|------------------------|---------------------------------|
| <input type="checkbox"/> Enteric isolation status | Details | <u>Defaults</u> | <u>Available Buttons</u> |
|---|---------|------------------------|---------------------------------|

Other

Precautions

| | | | |
|---|--|------------------------|---------------------------------|
| <input type="checkbox"/> Aspiration precautions | Comments: Process Instructions: Phase of Care: | <u>Defaults</u> | <u>Available Buttons</u> |
|---|--|------------------------|---------------------------------|

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|---|--|------------------------|---|
| <input type="checkbox"/> Fall precautions | Increased observation level needed: Additional Questions: | <u>Defaults</u> | <u>Available Buttons</u> if (answer = Yes) Level: For: Time: |
| | Comments: Process Instructions: Phase of Care: | | |

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|--|--|------------------------|---------------------------------|
| <input type="checkbox"/> Latex precautions | Comments: Process Instructions: Phase of Care: | <u>Defaults</u> | <u>Available Buttons</u> |
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|--|--|------------------------|---|
| <input type="checkbox"/> Seizure precautions | Increased observation level needed: Additional Questions: | <u>Defaults</u> | <u>Available Buttons</u> if (answer = Yes) Level: For: Time: |
| | Comments: Process Instructions: Phase of Care: | | |

Other

Nursing

Nursing Care

| | | |
|--|------------------------|---------------------------------|
| <input type="checkbox"/> Insert feeding tube | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | Once | [Once] [Q4H] [Q Shift] [Daily] |
| Comments: | | |
| Phase of Care: | | |

| | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> HOB 30 degrees | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | Until discontinued, Starting S | |
| Head of bed: | 30 degrees | [flat] [30 degrees] [45 degrees] [60 degrees] |
| Additional Questions: | | if (answer = other degrees (specify)) Specify: |
| Comments: | Twice daily | |
| Phase of Care: | | |

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|---|------------------------|---------------------------------|
| <input type="checkbox"/> Nasogastric Tube Insert and Maintain | | |
| <input type="checkbox"/> Nasogastric tube insertion | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | Once | [Once] |
| Type: | | [Salem Sump] [Dobhoff] [Other] |
| Additional Questions: | | if (answer = Other) Other: |
| Comments: | | |
| Phase of Care: | | |

| | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Nasogastric tube maintenance | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] |
| Frequency: | Until discontinued, Starting S | [Once] [Until Discontinued] |
| Tube Care Orders: | | [To Low Intermittent Suction] [To Continuous Suction] [To Gravity] [Clamp] [Flush Every 8 Hours] |
| Comments: | | |
| Phase of Care: | | |

| | | |
|--|------------------------|---|
| <input type="checkbox"/> Insert and Maintain Foley | | |
| <input type="checkbox"/> Insert Foley catheter | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | Once | [Once] [Q4H] [Q Shift] [Daily] |
| Type: | | [2 Way] [3 Way] [Coude] [Temperature Sensing] |
| Size: | | [14 French] [16 French] [18 French] |
| Urinometer needed: | | |
| Comments: | | |
| Phase of Care: | | |

| | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Foley Catheter Care | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | Until discontinued, Starting S | [Until Discontinued] [Daily] |
| Orders: | Maintain | [to gravity] [to leg bag] [flush] [flush until clear] [Site care Qshift & PRN] [Maintain] [Irrigate urinary catheter PRN] [Do not manipulate] |
| Comments: | | |
| Phase of Care: | | |

| | | |
|---------------------------------|--|---|
| [] First Step Plus Mattress | Defaults | Available Buttons |
| | Priority: Routine | [Routine] [STAT] |
| | Frequency: Once | |
| | Clinical Indications: Criteria 1, or Criteria 2 or 3 and at least one of 4-7: | [(1) Completely Immobile (cannot make positional changes without assist).] [(2) Limited mobility (cannot make positional canges to alleviate pressure).] [(3) Any stage pressure ulcer on the trunk or pelvis.] [(4) Impaired nutritional status] [(5) Fecal or urinary incontinence.] [(6) Altered sensory perception] [(7) Compromised circulatory status.] |
| | Special Instructions: | |
| Weight: | | |
| Comments: | | |
| Phase of Care: | | |

[] Other

Activity

| | | |
|---------------------|--|--|
| [] Strict bed rest | Defaults | Available Buttons |
| | Priority: Routine | [Routine] |
| | Frequency: Until discontinued, Starting S | [Until Discontinued] [Q Shift] [Daily] |
| | Comments: | |
| | Phase of Care: | |

| | | |
|---|--|--|
| [] Bed rest with bathroom privileges | Defaults | Available Buttons |
| | Priority: Routine | [Routine] |
| | Frequency: Until discontinued, Starting S | [Until Discontinued] [Q Shift] [Daily] |
| | Bathroom Privileges: with bathroom privileges | [with bathroom privileges] [with bedside commode] |
| | Comments: | |
| Phase of Care: | | |

| | | |
|---------------------------------|---------------------------------|---|
| [] Ambulate with assistance | Defaults | Available Buttons |
| | Priority: Routine | [Routine] |
| | Frequency: 3 times daily | [Until Discontinued] [Q Shift] [Daily] |
| | Specify: with assistance | [in hall] [in room] [with assistance] [with assistive device] |
| | Additional Questions: | if (answer = with assistive device) Device: if (answer = other (specify)) Specify: |
| Comments: | | |
| Phase of Care: | | |

| | | |
|------------------------------|--|--|
| [] Activity as tolerated | Defaults | Available Buttons |
| | Priority: Routine | [Routine] |
| | Frequency: Until discontinued, Starting S | [Until Discontinued] [Q Shift] [Daily] |
| | Specify: Activity as tolerated | [Activity as tolerated] [Up ad lib] [Out of bed] [Up in chair] [Up with assistance] [Other activity (specify)] |
| | Additional Questions: | if (answer = Up in chair) Additional modifier: if (answer = Other activity (specify)) Other: |
| Comments: | | |
| Phase of Care: | | |

[] Other

Diet

NPO

| | Defaults | Available Buttons |
|--------------------------------|---------------------------------------|--|
| Frequency: | Diet effective now, Starting S | [Effective Midnight] [Effective Now] [Effective 0500 (Breakfast)] [Effective 1000 (Lunch)] [Effective 1400 (Dinner)] [Effective _____] |
| NPO: | | [Except meds] [Except Ice chips] [Except Sips with meds] [Except Sips of clear liquids] |
| Pre-Operative fasting options: | | |
| Additional Questions: | | if (answer = Other) Specify: |
| Comments: | | |
| Phase of Care: | | |

Diet Clear Liquids

| | Defaults | Available Buttons |
|----------------------------|---------------------------------------|--|
| Frequency: | Diet effective now, Starting S | [Effective Now] [Effective 0500 (Breakfast)] [Effective 1000 (Lunch)] [Effective 1400 (Dinner)] [Effective Midnight] [Effective _____] [Effective tomorrow] |
| Diet(s): | Clear Liquids | [Regular] [Clear Liquids] [Full Liquids] [Easy to digest (GERD)] [No Carbohydrate Clear Liquid] [Low Carbohydrate Full Liquid] [Renal (80GM Pro, 2-3GM Na, 2-3GM K)] [2000 Kcal/225 gm Carbohydrate] [Heart Healthy] [Fiber Restricted] [Post Gastrectomy] [Post Transplant] [Post Esophagectomy] [Low Fat] [2 GM Potassium] [Neutropenic/Low Bacteria] [2 GM Sodium] [Dysphagia] [Bariatric] [Cultural/Special] [Other Diabetic/Cal] [Other Protein] |
| Additional Questions: | | if (answer = Dysphagia) Solid Consistency: if (answer = Other Diabetic/Cal) Diabetic/Calorie: if (answer = Other Protein) Protein: if (answer = Bariatric) Bariatric: if (answer = Cultural/Special) Cultural/Special: |
| Advance Diet as Tolerated? | | |
| Additional Questions: | | if (answer = Yes) Target Diet: Advance target diet criteria: |
| Liquid Consistency: | | [Thick Liquids-Honey Like] [Thick Liquids-Nectar Like] |
| Fluid Restriction: | | [Fluid Restriction 500 ml] [Fluid Restriction 800 ml] [Fluid Restriction 1000 ml] [Fluid Restriction 1200 ml] [Fluid Restriction 1500 ml] [No Fluids] |
| Foods to Avoid: | | |
| Comments: | | |
| Phase of Care: | | |

Diet

| | Defaults | Available Buttons |
|------------|----------------------------|--|
| Frequency: | Diet effective now, | [Effective Now] [Effective 0500 (Breakfast)] |

| | | |
|----------------------------|-------------------|---|
| | Starting S | [Effective 1000 (Lunch)] [Effective 1400 (Dinner)] [Effective Midnight] [Effective _____] [Effective tomorrow] |
| Diet(s): | | [Regular] [Clear Liquids] [Full Liquids] [Easy to digest (GERD)] [No Carbohydrate Clear Liquid] [Low Carbohydrate Full Liquid] [Renal (80GM Pro, 2-3GM Na, 2-3GM K)] [2000 Kcal/225 gm Carbohydrate] [Heart Healthy] [Fiber Restricted] [Post Gastrectomy] [Post Transplant] [Post Esophagectomy] [Low Fat] [2 GM Potassium] [Neutropenic/Low Bacteria] [2 GM Sodium] [Dysphagia] [Bariatric] [Cultural/Special] [Other Diabetic/Cal] [Other Protein] |
| Additional Questions: | | if (answer = Dysphagia) Solid Consistency: if (answer = Other Diabetic/Cal) Diabetic/Calorie: if (answer = Other Protein) Protein: if (answer = Bariatric) Bariatric: if (answer = Cultural/Special) Cultural/Special: |
| Other Options: | | [Finger Foods] [Safety Tray] |
| Advance Diet as Tolerated? | | |
| Additional Questions: | | if (answer = Yes) Target Diet: Advance target diet criteria: |
| Liquid Consistency: | | [Thick Liquids-Honey Like] [Thick Liquids-Nectar Like] |
| Fluid Restriction: | | [Fluid Restriction 500 ml] [Fluid Restriction 800 ml] [Fluid Restriction 1000 ml] [Fluid Restriction 1200 ml] [Fluid Restriction 1500 ml] [No Fluids] |
| Foods to Avoid: | | |
| Comments: | | |
| Phase of Care: | | |

Tube feeding

| | Defaults | Available Buttons |
|-----------------------|---------------------------------------|---|
| Frequency: | Diet effective now, Starting S | [HS only] [Q4H] [Q6H] [Q8H] [TID] [4x Daily] [5x Daily] [6x Daily] [Cyclic] [Daily] [BID] |
| Tube Feeding Formula: | | [Compleat] [Isosource HN] [Isosource 1.5] [Fibersource HN] [Replete] [Nutren 2.0] [Diabetisource AC] [Novasource Renal] [Suplena With Carb Steady] [Peptamen AF] [Peptamen Intense VHP] [Peptamen 1.5] [Impact Peptide 1.5] [Vivonex RTF] |
| Tube Feeding Formula: | | [Isosource 1.5] [Fibersource HN] [Diabetisource AC] [Novasource Renal] [Nutren 2.0] [Peptamen AF] [Peptamen Intense VHP] [Peptamen 1.5] [Vivonex RTF] [Replete] |
| Tube Feeding Formula: | | [Isosource HN] [Isosource 1.5] [Fibersource HN] [Diabetisource AC] [Novasource Renal] [Suplena With Carb Steady] [Peptamen AF] [Peptamen Intense VHP] [Peptamen 1.5 with Prebio] |

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|------------------------|--|
| | [Impact Peptide 1.5] [Nutrihep] [Nutren Junior] |
| Tube Feeding Formula: | [Isosource HN] [Isosource 1.5] [Impact Peptide 1.5] [Nutren 2.0] [Diabetisource AC] [Novasource Renal] [Suplena With Carb Steady] [Peptamen AF] [Peptamen Intense VHP] [Peptamen 1.5] [Vivonex RTF] |
| Tube Feeding Formula: | [Impact Peptide 1.5] [Isosource 1.5] [Fibersource HN] [Diabetisource AC] [Novasource Renal] [Peptamen AF] [Peptamen Intense VHP] [Replete] [Vivonex RTF] |
| Tube Feeding Formula: | [Fibersource HN] [Nutren 1.5] [Diabetisource AC] [Novasource Renal] [Peptamen AF] [Impact Peptide 1.5] [Peptamen Intense] |
| Tube Feeding Formula: | [Compleat] [Impact Peptide 1.5] [Isosource 1.5] [Fibersource HN] [Diabetisource AC] [Novasource Renal] [Peptamen AF] [Peptamen Intense VHP] [Peptamen 1.5] [Vivonex RTF] [Nutren 2.0] |
| Tube Feeding Formula: | [Isosource HN] [Isosource 1.5] [Diabetisource AC] [Novasource Renal] [Nutren 2.0] [Peptamen AF] [Peptamen Intense VHP] [Peptamen 1.5] [Replete] |
| Tube Feeding Schedule: | [Continuous] [Bolus] [Cyclic] |
| Additional Questions: | <p>if (answer = Continuous) Rate Based or Volume Based Feeding? if (answer = Rate Based Feeding) Tube Feeding Route: Initial Tube Feed rate (mL/hr): Advance Rate by (mL/hr): if (answer = 10 mL/hr) Or (answer = 15 mL/hr) Or (answer = 20 mL/hr) Or (answer = 25 mL/hr) Or (answer = 30 mL/hr) Every (Specify) Hr(s): if (answer = Other) Specify: Goal Tube Feed Rate (mL/hr): if (answer = Volume Based Feeding (For Certain ICUs Only)) Tube Feeding Route: if (answer = Nasoenteric) Rationale: Initial Tube Feed rate (mL/hr): Goal Tube Feed Rate (mL/hr): Total Fluid Volume in 24 Hours (mL): if (answer = Bolus) Bolus Route: Tube Feeding Bolus (mL): Additional Bolus Schedule Instructions: if (answer = Cyclic) Tube Feeding Route: Tube Feeding Cyclic (start / stop time): Tube Feeding Cyclic Rate (mL/hr):</p> |
| Tube Feeding Schedule: | [Continuous] [Bolus] [Cyclic] |
| Additional Questions: | if (answer = Continuous) |

Tube Feeding Route:
 Initial Tube Feed rate (mL/hr):
 Advance Rate by (mL/hr):
 if (answer = 10 mL/hr) Or (answer = 15 mL/hr) Or (answer = 20 mL/hr) Or (answer = 25 mL/hr) Or (answer = 30 mL/hr)
 Every (Specify) Hr(s):
 if (answer = Other)
 Specify:
 Goal Tube Feed Rate (mL/hr):
 if (answer = Bolus)
 Bolus Route:
 Tube Feeding Bolus (mL):
 Additional Bolus Schedule Instructions:
 if (answer = Cyclic)
 Tube Feeding Route:
 Tube Feeding Cyclic (start / stop time):
 Tube Feeding Cyclic Rate (mL/hr):

Dietitian to manage

Tube Feed?

Comments:

Phase of Care:

Other

IV Fluids

IV Bolus (Single Response)

() sodium chloride
0.9 % bolus 500
mL

| | <u>Defaults</u> | <u>Available Buttons</u> |
|------------------------------|-----------------------|--------------------------------|
| Dose: | 500 mL | [500 mL] [1,000 mL] |
| Route: | intravenous | [intravenous] |
| Rate: | | |
| Duration: | for 15 Minutes | [15] [30] [60] [90] [120] |
| Frequency: | once | [Once] |
| Frequency Start: | | |
| Frequency Dose: | For 1 Doses | |
| Phase of Care: | | |
| Administration instructions: | | |
| Indications: | | |

() sodium chloride
0.9 % bolus 1000
mL

| | <u>Defaults</u> | <u>Available Buttons</u> |
|------------------------------|-----------------------|--------------------------------|
| Dose: | 1,000 mL | [500 mL] [1,000 mL] |
| Route: | intravenous | [intravenous] |
| Rate: | | |
| Duration: | for 30 Minutes | [15] [30] [60] [90] [120] |
| Frequency: | once | [Once] |
| Frequency Start: | | |
| Frequency Dose: | For 1 Doses | |
| Phase of Care: | | |
| Administration instructions: | | |
| Indications: | | |

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|-----------------------------------|------------------------------|------------------------|--|
| () lactated ringer's bolus 500 mL | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 500 mL | [250 mL] [500 mL] [1,000 mL] |
| | Route: | intravenous | [intravenous] |
| | Rate: | | |
| | Duration: | for 15 Minutes | [15 Minutes] [30 Minutes] [60 Minutes] |
| | Frequency: | once | [Once] |
| | Frequency Start: | | |
| | Frequency Dose: | For 1 Doses | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| Indications: | | | |

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|-----------------------------------|------------------------------|------------------------|--|
| () lactated ringers bolus 1000 mL | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 1,000 mL | [250 mL] [500 mL] [1,000 mL] |
| | Route: | intravenous | [intravenous] |
| | Rate: | | |
| | Duration: | for 30 Minutes | [15 Minutes] [30 Minutes] [60 Minutes] |
| | Frequency: | once | [Once] |
| | Frequency Start: | | |
| | Frequency Dose: | For 1 Doses | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| Indications: | | | |

[] Other

Maintenance IV Fluids (Single Response)

| | | | |
|-----------------------------------|------------------------------|------------------------|---------------------------------|
| () sodium chloride 0.9 % infusion | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 75 mL/hr | |
| | Route: | intravenous | [intravenous] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | continuous | [Continuous] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| Indications: | | | |

| | | | |
|-------------------------------|------------------------------|------------------------|---|
| () lactated Ringer's infusion | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 75 mL/hr | [50 mL/hr] [75 mL/hr] [100 mL/hr] [125 mL/hr] |
| | Route: | intravenous | [intravenous] |
| | Rate: | | |
| | Duration: | | [1 Hours] [4 Hours] [8 Hours] |
| | Frequency: | continuous | [Continuous] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| Indications: | | | |

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|--|------------------------------|---------------------------------|---|
| <input type="checkbox"/> dextrose 5 % and sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion | <u>Defaults</u> | <u>Available Buttons</u> | |
| | Dose: | 75 mL/hr | [50 mL/hr] [75 mL/hr] [100 mL/hr] [125 mL/hr] |
| | Route: | intravenous | [intravenous] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | continuous | [Continuous] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| | Indications: | | [hypokalemia] [hypokalemia prevention] |

| | | | |
|--|------------------------------|---------------------------------|---------------|
| <input type="checkbox"/> sodium chloride 0.45 % infusion | <u>Defaults</u> | <u>Available Buttons</u> | |
| | Dose: | 75 mL/hr | |
| | Route: | intravenous | [intravenous] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | continuous | [Continuous] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| | Indications: | | |

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|--|------------------------------|---------------------------------|---|
| <input type="checkbox"/> sodium chloride 0.45 % 1,000 mL with sodium bicarbonate 75 mEq/L infusion | <u>Defaults</u> | <u>Available Buttons</u> | |
| | Dose: | 75 mL/hr | [50 mL/hr] [75 mL/hr] [100 mL/hr] [125 mL/hr] |
| | Route: | intravenous | [intravenous] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | continuous | [Continuous] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| | Indications: | | |

Other

Insert and Maintain IV (Single Response)

Insert and Maintain IV - 10mL

| | | | |
|---|------------------------|---------------------------------|-----------|
| <input type="checkbox"/> Insert peripheral IV | <u>Defaults</u> | <u>Available Buttons</u> | |
| | Priority: | Routine | [Routine] |
| | Frequency: | Once | [Once] |
| | Comments: | | |
| | Phase of Care: | | |

| | | | | | | |
|------------------------------------|---------------------------------|-------------------------------------|---------------------------------|------------------|--------|---------|
| [] sodium chloride 0.9 % flush | <u>Defaults</u> | | <u>Available Buttons</u> | | | |
| | Dose: | 10 mL | [2 mL] | [3 mL] | [5 mL] | [10 mL] |
| | Route: | intravenous | [intravenous] | [intra-catheter] | | |
| | Rate: | | | | | |
| | Duration: | | | | | |
| | Frequency: | every 12 hours scheduled | [Q8H] | [PRN] | | |
| | Frequency Start: | | | | | |
| | Frequency Dose: | | | | | |
| | Phase of Care: | | | | | |
| | Administration instructions: | | | | | |
| Indications: | | | | | | |

| | | | | | | |
|------------------------------------|------------------------|--------------------|---------------------------------|------------------|--------|---------|
| [] sodium chloride 0.9 % flush | <u>Defaults</u> | | <u>Available Buttons</u> | | | |
| | Dose: | 10 mL | [2 mL] | [3 mL] | [5 mL] | [10 mL] |
| | Route: | intravenous | [intravenous] | [intra-catheter] | | |
| | Rate: | | | | | |
| | Duration: | | | | | |
| | Frequency: | PRN | [Q8H] | [PRN] | | |
| | PRN comment: | line care | [line care] | | | |
| | Frequency Start: | | | | | |
| | Frequency Dose: | | | | | |
| | Phase of Care: | | | | | |
| Administration instructions: | | | | | | |
| Indications: | | | | | | |

() Insert and Maintain Peripheral IV - 3mL

| | | | | | | |
|--------------------------|------------------------|----------------|---------------------------------|--|--|--|
| [] Insert peripheral IV | <u>Defaults</u> | | <u>Available Buttons</u> | | | |
| | Priority: | Routine | [Routine] | | | |
| | Frequency: | Once | [Once] | | | |
| | Comments: | | | | | |
| | Phase of Care: | | | | | |

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|------------------------------------|---------------------------------|-------------------------------------|---------------------------------|------------------|--------|---------|
| [] sodium chloride 0.9 % flush | <u>Defaults</u> | | <u>Available Buttons</u> | | | |
| | Dose: | 3 mL | [2 mL] | [3 mL] | [5 mL] | [10 mL] |
| | Route: | intravenous | [intravenous] | [intra-catheter] | | |
| | Rate: | | | | | |
| | Duration: | | | | | |
| | Frequency: | every 12 hours scheduled | [Q8H] | [PRN] | | |
| | Frequency Start: | | | | | |
| | Frequency Dose: | | | | | |
| | Phase of Care: | | | | | |
| | Administration instructions: | | | | | |
| Indications: | | | | | | |

| | | | | | | |
|------------------|------------------------|--------------------------|---------------------------------|--|--|--|
| [] IV site care | <u>Defaults</u> | | <u>Available Buttons</u> | | | |
| | Priority: | Routine | [Routine] | | | |
| | Frequency: | Per unit protocol | | | | |
| | Comments: | | | | | |
| | Phase of Care: | | | | | |

sodium chloride
0.9 % flush

| | <u>Defaults</u> | <u>Available Buttons</u> |
|------------------------------|-----------------|--------------------------------|
| Dose: | 3 mL | [2 mL] [3 mL] [5 mL] [10 mL] |
| Route: | intravenous | [intravenous] [intra-catheter] |
| Rate: | | |
| Duration: | | |
| Frequency: | PRN | [Q8H] [PRN] |
| PRN comment: | | [line care] |
| Frequency Start: | | |
| Frequency Dose: | | |
| Phase of Care: | | |
| Administration instructions: | | |
| Indications: | | |

Other

Medications

Antibiotics

vancomycin
(VANCOCIN) IV

| | <u>Defaults</u> | <u>Available Buttons</u> |
|------------------------------|-----------------|--|
| Dose: | | |
| Route: | intravenous | [intravenous] |
| Rate: | | |
| Duration: | | |
| Frequency: | | |
| Frequency Start: | | |
| Frequency Dose: | | |
| Phase of Care: | | |
| Administration instructions: | | |
| Reason for Therapy: | | [Bacterial Infection Suspected] [Bacterial Infection Documented] [Surgical Prophylaxis] [Medical Prophylaxis] [Other] |
| Additional Questions: | | if (answer = Other) Specify: if (answer = Bacterial Infection Suspected) Indication: if (answer = Other) Specify: if (answer = Bacterial Infection Documented) Indication: if (answer = Other) Specify: |
| Indications: | | |

[] piperacillin-tazobac
tam (ZOSYN) IV

Defaults

Available Buttons

| | | |
|------------------------------|--------------------|--|
| Dose: | | |
| Route: | intravenous | [intravenous] |
| Rate: | | |
| Duration: | | [.5 Hours] [4 Hours] |
| Frequency: | | |
| Frequency Start: | | |
| Frequency Dose: | | |
| Phase of Care: | | |
| Administration instructions: | | |
| Reason for Therapy: | | [Bacterial Infection Suspected] [Bacterial Infection Documented] [Surgical Prophylaxis] [Medical Prophylaxis] [Other] |
| Additional Questions: | | if (answer = Other) Specify: if (answer = Bacterial Infection Suspected) Indication: if (answer = Other) Specify: if (answer = Bacterial Infection Documented) Indication: if (answer = Other) Specify: |
| Indications: | | |

[] linezolid (ZYVOX)
IV

Defaults

Available Buttons

| | | |
|------------------------------|-----------------------|--|
| Dose: | | |
| Route: | intravenous | [intravenous] |
| Rate: | | |
| Duration: | for 60 Minutes | [60 Minutes] [120 Minutes] |
| Frequency: | every 12 hours | [Once] [Q12H] |
| Frequency Start: | | |
| Frequency Dose: | | |
| Phase of Care: | | |
| Administration instructions: | | |
| Reason for Therapy: | | [Bacterial Infection Suspected] [Bacterial Infection Documented] [Surgical Prophylaxis] [Medical Prophylaxis] [Other] |
| Additional Questions: | | if (answer = Other) Specify: if (answer = Bacterial Infection Suspected) Indication: if (answer = Other) Specify: if (answer = Bacterial Infection Documented) Indication: if (answer = Other) Specify: |
| Indications: | | [anthrax septicemia] [meningitis due to anthrax] [vancomycin-resistant Enterococcus faecium infection] [streptococcal pneumonia] [staphylococcal pneumonia] [Staphylococcus nosocomial pneumonia] [Staphylococcus aureus skin and skin structure infection] [skin and skin structure Strep. pyogenes infection] [complicated skin and skin structure S. aureus infection] [complicated skin structure S. agalactiae infection] [complicated skin structure S. pyogenes infection] [bone infection] [vancomycin resistant Enterococcus faecium bacteremia] [nosocomial pneumonia due to Streptococcus pneumoniae] [diabetic foot infection due to gram-positive bacteria] [pediatric fever without a source] [pulmonary multi-drug resistant M. tuberculosis] |

[] meropenem (MERREM) IV

Defaults

Available Buttons

| | | |
|------------------------------|--------------------|--|
| Dose: | | |
| Route: | intravenous | [intravenous] |
| Rate: | | |
| Duration: | | |
| Frequency: | | |
| Frequency Start: | | |
| Frequency Dose: | | |
| Phase of Care: | | |
| Administration instructions: | | |
| Reason for Therapy: | | [Bacterial Infection Suspected] [Bacterial Infection Documented] [Surgical Prophylaxis] [Medical Prophylaxis] [Other] |
| Additional Questions: | | if (answer = Other) Specify: if (answer = Bacterial Infection Suspected) Indication: if (answer = Other) Specify: if (answer = Bacterial Infection Documented) Indication: if (answer = Other) Specify: |
| Indications: | | |

[] cefepime (MAXIPIME) IV

Defaults

Available Buttons

| | | |
|------------------------------|--------------------|--|
| Dose: | | [1 g] [2 g] |
| Route: | intravenous | [intravenous] |
| Rate: | | |
| Duration: | | |
| Frequency: | | [Once] [Q6H] [Q8H] [Q12H] |
| Frequency Start: | | |
| Frequency Dose: | | |
| Phase of Care: | | |
| Administration instructions: | | |
| Reason for Therapy: | | [Bacterial Infection Suspected] [Bacterial Infection Documented] [Surgical Prophylaxis] [Medical Prophylaxis] [Other] |
| Additional Questions: | | if (answer = Other) Specify: if (answer = Bacterial Infection Suspected) Indication: if (answer = Other) Specify: if (answer = Bacterial Infection Documented) Indication: if (answer = Other) Specify: |
| Indications: | | |

[] metroNIDAZOLE
(FLAGYL) tablet

| | <u>Defaults</u> | <u>Available Buttons</u> |
|------------------------------|-----------------|---|
| Dose: | 500 mg | [250 mg] [500 mg] |
| Route: | oral | [oral] |
| Rate: | | |
| Duration: | | |
| Frequency: | 3 times daily | [BID] [TID] |
| Frequency Start: | | |
| Frequency Dose: | | |
| Phase of Care: | | |
| Administration instructions: | | |
| Reason for Therapy: | | [Bacterial Infection Suspected] [Bacterial Infection Documented] [Surgical Prophylaxis] [Medical Prophylaxis] [Other] |
| Additional Questions: | | if (answer = Bacterial Infection Suspected) Indication: if (answer = Other) Specify: if (answer = Bacterial Infection Documented) Indication: if (answer = Other) Specify: if (answer = Other) Specify: |
| Indications: | | [acute intestinal amebiasis due to Entamoeba histolytica] [liver abscess amebiasis due to Entamoeba histolytica] [balantidiasis] [giardiasis] [Clostridium difficile infection] [Bacteroides septicemia] [Clostridium septicemia] [B. fragilis infection] [Bacteroides brain abscess] [dracunculiasis] [trichomoniasis] [meningitis due to Bacteroides] [Bacteroides endocarditis] [Bacteroides pneumonia] [Bacteroides empyema] [lower respiratory infection] [periodontal infection] [duodenal ulcer due to H. pylori] [peptic ulcer due to H. pylori] [Helicobacter pylori gastritis] [Crohn's disease] [diverticulitis of gastrointestinal tract] [Bacteroides peritonitis] [Clostridium peritonitis] [Peptococcus peritonitis] [Peptostreptococcus peritonitis] [Eubacterium peritonitis] [intra-abdominal Bacteroides abscess] [intra-abdominal Clostridium abscess] [intra-abdominal Eubacterium abscess] [intra-abdominal Peptococcus abscess] [intra-abdominal Peptostreptococcus abscess] [intra-abdominal anaerobic abscess] [infectious disease of abdomen] [Bacteroides liver abscess] [Clostridium liver abscess] [Eubacterium liver abscess] [Peptococcus liver abscess] [Peptostreptococcus liver abscess] [Bacteroides tubo-ovarian abscess] [Clostridium tubo-ovarian abscess] [Peptococcus tubo-ovarian abscess] [Peptostreptococcus tubo-ovarian abscess] [inflammatory disease of female pelvic organs] [endometritis] [Clostridium endometritis] [Peptococcus endometritis] [Peptostreptococcus endometritis] |

metronidazole
(FLAGYL) IV

Defaults

Available Buttons

Dose:

Route:

intravenous

[intravenous]

Rate:

Duration:

Frequency:

[Once] [Q6H] [Q8H] [Q12H]

Frequency Start:

Frequency Dose:

Phase of Care:

Administration

instructions:

Reason for Therapy:

[Bacterial Infection Suspected] [Bacterial
Infection Documented] [Surgical
Prophylaxis] [Medical Prophylaxis]
[Other]

Additional Questions:

if (answer = Bacterial Infection Suspected)

Indication:

if (answer = Other)

Specify:

if (answer = Bacterial Infection
Documented)

Indication:

if (answer = Other)

Specify:

if (answer = Other)

Specify:

Indications:

Other

Antihypertensives

[] metoprolol tartrate (LOPRESSOR) tablet

| | <u>Defaults</u> | <u>Available Buttons</u> |
|---------------------------------|------------------------------------|--|
| Dose: | 25 mg | [12.5 mg] [25 mg] [50 mg] [75 mg] [100 mg] |
| Route: | oral | [oral] |
| Rate: | | |
| Duration: | | |
| Frequency: | 2 times daily at 0600, 1800 | [Once] [BID] |
| Frequency Start: | | |
| Frequency Dose: | | |
| Phase of Care: | | |
| Administration instructions: | | |
| HOLD parameters for this order: | | [No Hold Parameters needed] [Hold Parameters requested] |
| Additional Questions: | | if (answer = Hold Parameters requested) HOLD for: if (answer = Other Systolic BP) Hold for Systolic BP LESS than (in mmHg): if (answer = Other Heart Rate) Hold for Heart Rate LESS than (in bpm): |
| Contact Physician if: | | |
| Indications: | | [pheochromocytoma adjunct therapy] [thyrotoxicosis] [migraine prevention] [hypertension] [acute myocardial infarction] [myocardial reinfarction prevention] [acute coronary syndrome] [paroxysmal supraventricular tachycardia] [akathisia] [multifocal atrial tachycardia] [ventricular rate control in atrial fibrillation] [prevent ventricular arrhythmia due to congenital long QT] [inappropriate sinus tachycardia] [prevention of anginal pain in coronary artery disease] |

| | | | |
|--------------------------------------|---------------------------------|--|--|
| [] metoprolol (LOPRESSOR) injection | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 5 mg | [2.5 mg] [5 mg] [10 mg] |
| | Route: | intravenous | [intravenous] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | | [Once] [Q5 Min PRN] [Q6H SCH] [Q8H SCH] [Q12H SCH] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | Maximum total dose is 15 mg over a 10-15 minute period. | |
| | HOLD parameters for this order: | | [No Hold Parameters needed] [Hold Parameters requested] |
| | Additional Questions: | | if (answer = Hold Parameters requested) HOLD for: if (answer = Other Systolic BP) Hold for Systolic BP LESS than (in mmHg): if (answer = Other Heart Rate) Hold for Heart Rate LESS than (in bpm): |
| | Contact Physician if: | | |
| | Indications: | | [acute myocardial infarction] [acute coronary syndrome] [paroxysmal supraventricular tachycardia] [ventricular tachycardia] [multifocal atrial tachycardia] [ectopic atrial tachycardia] [ventricular rate control in atrial fibrillation] |

| | | | |
|------------------------------------|------------------------------|---|--|
| [] labetalol (TRANDATE) injection | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | | [2.5 mg] [5 mg] [10 mg] [15 mg] [20 mg] [40 mg] [80 mg] |
| | Route: | intravenous | [intravenous] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | PRN | |
| | PRN comment: | high blood pressure | [high blood pressure] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | Administer if Systolic BP GREATER than *** | |
| | Indications: | | [pheochromocytoma adjunct therapy] [hypertension] [angina] |

| | | | |
|--|---------------------------------|--|---|
| [] hydrALAZINE (APRESOLINE) injection | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 10 mg | [2.5 mg] [5 mg] [10 mg] [20 mg] |
| | Route: | intravenous | [intravenous] [intramuscular] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | | |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | Administer if Systolic BP GREATER than *** | |
| | HOLD parameters for this order: | | [No Hold Parameters needed] [Hold Parameters requested] |
| | Additional Questions: | | if (answer = Hold Parameters requested) HOLD for: if (answer = Other Systolic BP) Hold for Systolic BP LESS than (in mmHg): if (answer = Other Heart Rate) Hold for Heart Rate LESS than (in bpm): |
| | Contact Physician if: | | |
| Indications: | | [hypertension] [chronic heart failure] | |

[] Other

Other Medications

| | | | |
|-------------------------------------|------------------------------|--|--|
| [] furosemide (LASIX) injection | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | | [20 mg] [40 mg] [60 mg] [80 mg] |
| | Route: | intravenous | [intravenous] [intramuscular] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | once | [Once] [Daily] [BID] [TID] [4x Daily] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | Inject each 20 mg of furosemide slowly IV over 1 to 2 minutes | |
| | Indications: | | [peripheral edema due to chronic heart failure] [pulmonary edema due to chronic heart failure] [acute decompensated heart failure] [acute pulmonary edema] [edema due to hepatic cirrhosis] [renal disease with edema] [edema] |

| | | | |
|--|------------------------------|------------------------|--|
| [] hydrocortisone sodium succinate (Solu-CORTEF) injection | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | | |
| | Route: | intravenous | [intravenous] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | every 6 hours | [Once] [Daily] [Q6H SCH] [Q8H SCH] [Q12H SCH] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| Indications: | | | |

| | | | |
|------------------------|------------------------------|---------------------------------|---|
| [] lactulose solution | <u>Defaults</u> | <u>Available Buttons</u> | |
| | Dose: | [10 g] [20 g] | |
| | Route: | oral | |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | 3 times daily | [Daily] [BID] [TID] [Daily PRN] [BID PRN] [TID PRN] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| | Indications: | | |

| | | | |
|---|--|---|---------------|
| [] omeprazole (PriLOSEC) oral suspension | <u>Defaults</u> | <u>Available Buttons</u> | |
| | Dose: | [20 mg] [40 mg] | |
| | Route: | oral | |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | daily | [Daily] [BID] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| | Indication(s) for Proton Pump Inhibitor (PPI) Therapy: | [Stress Ulcer Prophylaxis(SUP) in a Critical Care Unit] [GERD] [GI ulcer (PUD, gastric, duodenal)] [H. Pylori infection] [Erosive esophagitis] [Pathological hypersecretory conditions (e.g., Zollinger-Ellison syndrome)] [NSAID-associated gastric ulcers or prophylaxis in patients at risk (age GREATER than or EQUAL to 60 years and/or history of gastric ulcer, dual antiplatelet therapy, treatment dose anticoagulant therapy)] [Active GI bleeding or history of GI bleeding in the last year] [Receiving GREATER than or EQUAL to 100mg hydrocortisone or its equivalent] [GREATER than or EQUAL to 60 years and on dual antiplatelet therapy] [GREATER than or EQUAL to 60 years and on treatment dose anticoagulant therapy] [Other (Specify)] | |
| Additional Questions: | if (answer = Other (Specify)) Specify: | | |
| Indications: | | | |

| | | |
|---|------------------------------|-----------------------------------|
| [] polyethylene glycol (GLYCOLAX) packet | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 17 g |
| | Route: | oral |
| | Rate: | |
| | Duration: | |
| | Frequency: | daily |
| | Frequency Start: | |
| | Frequency Dose: | |
| | Phase of Care: | |
| | Administration instructions: | |
| | Indications: | [bowel evacuation] [constipation] |

| | | | |
|---|------------------------------|------------------------|---------------------------------|
| [] norepinephrine (LEVOPHED) injection | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 200 mcg | [5 mcg] [10 mcg] [20 mcg] |
| | Route: | intravenous | |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | once | |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| | Indications: | | |

[] Other

PRN Pain Medications (Single Response)

| | | | |
|------------------------------------|------------------------------|-----------------------------|--|
| () fentaNYL (SUBLIMAZE) injection | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 50 mcg | |
| | Route: | intravenous | [intravenous] [intramuscular] [subcutaneous] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | every 3 hours PRN | [Q1H PRN] [Q2H PRN] [Once] |
| | PRN comment: | severe pain (score 7-10) | [moderate pain (score 4-6)] [severe pain (score 7-10)] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| Indications: | acute pain | [acute pain] [chronic pain] | |

| | | | |
|------------------------|------------------------------|--------------------------|--|
| () morPHINE injection | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 4 mg | |
| | Route: | intravenous | [intravenous] [intramuscular] [subcutaneous] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | every 3 hours PRN | [Once] [Q2H PRN] [Q3H PRN] [Q4H PRN] |
| | PRN comment: | severe pain (score 7-10) | [moderate pain (score 4-6)] [severe pain (score 7-10)] [shortness of breath] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| | Administration instructions: | | |
| Indications: | | | |

| | | | |
|---|------------------|---------------------------------|--|
| <input type="checkbox"/> hydromorPHONE (DILAUDID) injection | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Dose: | 0.8 mg | |
| | Route: | intravenous | [intravenous] [intramuscular] [subcutaneous] |
| | Rate: | | |
| | Duration: | | |
| | Frequency: | every 3 hours PRN | [Once] [Q2H PRN] [Q3H PRN] [Q4H PRN] |
| | PRN comment: | severe pain (score 7-10) | [moderate pain (score 4-6)] [severe pain (score 7-10)] [other] |
| | Frequency Start: | | |
| | Frequency Dose: | | |
| | Phase of Care: | | |
| Administration instructions: | | | |
| Indications: | | | |

Other

Pharmacy Consults

| | | | |
|---|------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Pharmacy consult to manage dose adjustments for renal function | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Priority: | STAT | [Routine] [STAT] |
| | Frequency: | Until discontinued, Starting S | [Until Discontinued] |
| | Adjust dose for: | | |
| Comments: | | | |

| | | | |
|--|-----------------------|---------------------------------------|--|
| <input type="checkbox"/> Pharmacy consult to manage Heparin: LOW Dose protocol(ACS/Stroke/Afib)- without titration boluses | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Priority: | STAT | [Routine] [STAT] |
| | Frequency: | Until discontinued, Starting S | [Until Discontinued] |
| | Heparin Indication: | | |
| | Additional Questions: | | if (answer = Other (specify)) Specify Other Heparin Indication: |
| | Specify: | | [Give initial Bolus] [No initial Bolus] |
| | Monitoring: | Anti-Xa | [Anti-Xa] [aPTT] |
| Comments: | | | |

| | | | |
|---|-----------------------|---------------------------------------|---|
| <input type="checkbox"/> Pharmacy consult to manage warfarin (COUMADIN) | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Priority: | Routine | [Routine] [STAT] |
| | Frequency: | Until discontinued, Starting S | [Until Discontinued] |
| | Indication: | | [Atrial fibrillation (Target INR 2-3)] [Deep venous thrombosis (Target INR 2-3)] [Mechanical heart valve (Target INR 2-3)] [Mechanical heart valve (Target INR 2.5-3.5)] [Pulmonary embolism (Target INR 2-3)] [Stroke or TIA (Target INR 2-3)] [LVAD (Specify Target INR)] [Other (Specify indication & Target INR)] |
| | Additional Questions: | | if (answer = Other (Specify indication & Target INR)) Specify indication & Target INR (free text): if (answer = LVAD (Specify Target INR)) Target INR: |
| | Comments: | | |

| | | | |
|---|-------------------------------|--------------------------------|---|
| <input type="checkbox"/> Pharmacy consult to manage TPN therapy | Priority: | Defaults STAT | Available Buttons [Routine] [STAT] |
| | Frequency: | Until discontinued, Starting S | [Until Discontinued] |
| | Enteral Nutrition: | | [Attempted and failed] [Not attempted] [Contraindicated] |
| | Indication: | | |
| | Additional Questions: | | if (answer = Other) Other: |
| | Location of venous access: | | [Central] [Peripheral] [Umbilical] |
| | Is patient volume restricted: | | |
| Comments: | | | |
| <input type="checkbox"/> Other | | | |

Labs

| Labs | | | |
|---|----------------|--|--|
| <input type="checkbox"/> Lactic acid, plasma | Frequency: | Defaults Once | Available Buttons [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| | Comments: | | |
| | Phase of Care: | | |
| <input type="checkbox"/> Comprehensive metabolic panel | Frequency: | Defaults Once | Available Buttons [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| | Comments: | | |
| | Phase of Care: | | |
| <input type="checkbox"/> Basic metabolic panel | Frequency: | Defaults Once | Available Buttons [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| | Comments: | | |
| | Phase of Care: | | |
| <input type="checkbox"/> CBC | Frequency: | Defaults Once | Available Buttons [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| | Comments: | CBC only; Does not include a differential | |
| | Phase of Care: | | |
| <input type="checkbox"/> CBC with platelet and differential | Frequency: | Defaults Once | Available Buttons [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| | Comments: | | |
| | Phase of Care: | | |
| <input type="checkbox"/> Blood gas, arterial | Frequency: | Defaults STAT For 1 Occurrences | Available Buttons [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| | Comments: | | |
| | Phase of Care: | | |
| <input type="checkbox"/> Magnesium | Frequency: | Defaults Once | Available Buttons [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| | Comments: | | |
| | Phase of Care: | | |

| | | |
|---|--|---|
| <input type="checkbox"/> Phosphorus Frequency: Comments: Phase of Care: | <u>Defaults</u> Once | <u>Available Buttons</u> [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| <input type="checkbox"/> Ionized calcium Frequency: Comments: Phase of Care: | <u>Defaults</u> Once | <u>Available Buttons</u> [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| <input type="checkbox"/> Prothrombin time with INR Frequency: Comments: Phase of Care: | <u>Defaults</u> Once | <u>Available Buttons</u> [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| <input type="checkbox"/> Hepatic function panel Frequency: Comments: Phase of Care: | <u>Defaults</u> Once | <u>Available Buttons</u> [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| <input type="checkbox"/> Vancomycin, trough Frequency: Comments: Phase of Care: | <u>Defaults</u> Timed, Starting S | <u>Available Buttons</u> [Once] [STAT] [AM Draw] [Timed] [Add-on] |
| <input type="checkbox"/> Vancomycin, peak Frequency: Comments: Phase of Care: | <u>Defaults</u> Once | <u>Available Buttons</u> [Once] [STAT] [AM Draw] [AM Draw Repeats] [Timed] [Add-on] |
| <input type="checkbox"/> Other | | |

Microbiology

Blood culture x 2 **"And" Linked Panel**

| | | | |
|---|------------------|---|---------------------------------|
| [] Blood Culture (Aerobic & Anaerobic) | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Frequency: | Once | [Once] [STAT] [AM Draw] [Timed] |
| | Specimen type: | Blood | |
| | Specimen source: | | |
| | Comments: | Collect before antibiotics given. Blood cultures should be ordered x2, with each set drawn from a different peripheral site. If unable to draw both sets from a peripheral site, please call the lab for assistance; an IV line should NEVER be used. | |
| Phase of Care: | | | |

| | | | |
|---|------------------|---|---------------------------------|
| [] Blood Culture (Aerobic & Anaerobic) | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Frequency: | Once | [Once] [STAT] [AM Draw] [Timed] |
| | Specimen type: | Blood | |
| | Specimen source: | | |
| | Comments: | Collect before antibiotics given. Blood cultures should be ordered x2, with each set drawn from a different peripheral site. If unable to draw both sets from a peripheral site, please call the lab for assistance; an IV line should NEVER be used. | |
| Phase of Care: | | | |

| | | | |
|--------------------|------------------|------------------------|--|
| [] Sputum culture | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Frequency: | Once | [Once] [AM Draw] [Timed] |
| | Specimen type: | Sputum | [Sputum] [Tracheal aspirate] |
| | Specimen source: | | [Expectorated] [Induced] [Not otherwise specified] |
| | Comments: | | |
| Phase of Care: | | | |

| | | | |
|----------------------|----------------|------------------------|---------------------------------|
| [] Culture, Routine | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Frequency: | Once | [Once] [STAT] [AM Draw] [Timed] |
| | Comments: | | |
| | Phase of Care: | | |

| | | | |
|-----------|--|--|--|
| [] Other | | | |
|-----------|--|--|--|

Cardiology

Cardiology

| | | |
|--------------------------------------|------------------------|-------------------------------------|
| <input type="checkbox"/> ECG 12 lead | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | |
| Frequency: | Once | [STAT] [Once] [Conditional] [Daily] |
| Clinical Indications: | | |
| Additional Questions: | | if (answer = Other:) Other: |
| Interpreting Physician: | | |
| Comments: | | |
| Phase of Care: | | |

| | | |
|---|------------------------|---------------------------------|
| <input type="checkbox"/> Echocardiogram 2d complete with contrast | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | 1 time imaging | |
| Comments: | | |
| Phase of Care: | | |

| | | |
|--------------------------------|--|--|
| <input type="checkbox"/> Other | | |
|--------------------------------|--|--|

Imaging

CT

| | | |
|---|-------------------------|---------------------------------|
| <input type="checkbox"/> CT Brain | | |
| <input type="checkbox"/> CT Head W Wo Contrast | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | 1 time imaging For 1 | [Once] |
| Comments: | | |
| Phase of Care: | | |

| | | |
|--|-------------------------|---------------------------------|
| <input type="checkbox"/> CT Head W Contrast | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | 1 time imaging For 1 | [Once] |
| Comments: | | |
| Phase of Care: | | |

| | | |
|---|-------------------------|---------------------------------|
| <input type="checkbox"/> CT Head Wo Contrast | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | 1 time imaging For 1 | [Once] |
| Comments: | | |
| Phase of Care: | | |

| | | |
|--------------------------------|--|--|
| <input type="checkbox"/> Other | | |
|--------------------------------|--|--|

X-Ray

| | | |
|---|------------------------|---------------------------------|
| <input type="checkbox"/> US Guided Vascular Access | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | 1 time imaging For 1 | [Once] |
| Comments: | | |
| Phase of Care: | | |

| | | |
|---|------------------------|---------------------------------|
| <input type="checkbox"/> Chest 1 Vw Portable | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | 1 time imaging For 1 | [Once] |
| Comments: | | |
| Phase of Care: | | |

| | | |
|---------------------------------------|------------------------|---------------------------------|
| <input type="checkbox"/> Abdomen 1 Vw | <u>Defaults</u> | <u>Available Buttons</u> |
| Priority: | Routine | [Routine] [STAT] |
| Frequency: | 1 time imaging For 1 | [Once] |
| Comments: | | |
| Phase of Care: | | |

| | | | |
|-----------------------|----------------|------------------------|---------------------------------|
| [] IR PICC Placement | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Priority: | Routine | [Routine] [STAT] |
| | Frequency: | 1 time imaging For 1 | [Once] |
| | Comments: | | |
| | Phase of Care: | | |

[] Other

Respiratory

Respiratory

| | | | |
|--------------------------|----------------|------------------------|---------------------------------|
| [] Incentive spirometry | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Priority: | Routine | [Routine] |
| | Frequency: | Once | [Once] [4x Daily] |
| | Comments: | | |
| | Phase of Care: | | |

| | | | |
|----------------|-----------------------|------------------------|---|
| [] Suctioning | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Priority: | Routine | [Routine] [STAT] |
| | Frequency: | As needed | [PRN] |
| | Route: | | [Endotracheal] [Nasotracheal] |
| | Additional Questions: | | if (answer = Other (Specify)) Specify: |

Comments:

Phase of Care:

[] Other

Consults

Ancillary Consults

| | | | |
|--------------------------------|-----------------------|------------------------|---|
| [] Consult to Case Management | | <u>Defaults</u> | <u>Available Buttons</u> |
| | Consult Reason: | | [Benefit Issues] [Discharge Planning] [Home Health] [Hospice] [Insurance Issues] [LTAC Referral] [Rehabilitation Referral] [SNF Referral] [DME] [Palliative Care Education] [LifeVest] [Other specify] |
| | Additional Questions: | | if (answer = Other specify) Specify: if (answer = Home Health) Face-to-Face Date: Reasons for Home Health Care: Home Health Services: if (answer = Skilled Nursing Evaluation & Treatment) Times per week: For: Days/Week/Weeks: if (answer = Physical Therapy Evaluation & Treatment) (PT) Times per week: For: Days/Week/Weeks: if (answer = Occupational Therapy Evaluation & Treatment) Times per week: For: Days/Week/Weeks: if (answer = Speech Language Pathology Evaluation & Treatment) Times per week: |

For:
Days/Week/Weeks:
if (answer = Social Worker)
Times per week:
For:
Days/Week/Weeks:
if (answer = Home Health Aide)
Times per week:
For:
Days/Week/Weeks:
if (answer = Home Infusion)
IV infusion needs:
if (answer = Labs)
IV Infusion Labs:
Every:
Lab results called to:
if (answer = IV Fluids)
Solution:
How often:
Start date:
Stop date:
if (answer = Antibiotics)
Antibiotic(s), please list:
Start date:
Stop date:
if (answer = Nutritional Supplies)
Nutritional DME:
if (answer = Bolus feeding)
Rate:
Formula:
if (answer = Continuous feeding)
Rate:
Formula:
if (answer = Home Wound Care)
Wound care questions:
if (answer = Dressing Instructions)
How often:
Clean with:
Cover with:
Duration:
if (answer = Pleurx)
PleurX choices:
Change every:
PleurX Duration:
if (answer = Wound vac)
Change how often:
Pressure (mmHg):
Therapy Settings:
if (answer = Other)
Specify:
if (answer = Dynamic Pressure
Control)
DCP Ratio:
Intensity:
Foam Type:
Type of Wound:
if (answer = Other)
Specify:
if (answer = Ostomy supplies)
Special ostomy supplies:
Clinical Findings:
if (answer = Other:)
Other Clinical Findings:
Homebound Status:

if (answer = Other:)
Other Homebound Status:
if (answer = Leaving home is medically
contraindicated due to)
Contraindication:
Special Instructions:
Resume home health services with
previous home health agency prior to the
hospital admission:
Face to Face Cert Statement:
if (answer = DME)
DME Diagnosis:
Type of DME:
if (answer = Mobility Aids)
MOBILITY AIDS: Per Payer
requirements; only ONE Mobility Aid may be
chosen from this list:
if (answer = Walkers (With 5 inch
Wheels))
Walkers (With 5 inch wheels):
if (answer = Walkers (Without
Wheels))
Walkers (Without Wheels):
if (answer = Wheelchair)
Wheelchair:
if (answer = Canes)
Canes:
if (answer = Crutches)
Crutches:
if (answer = 3 in 1 Bedside Commode)
3-in-1 Bedside Commode:
if (answer = Respiratory Equipment)
Oxygen:
if (answer = O2 Portable Gas)
Continuous or PRN Oxygen:
O2 Duration:
O2 Sat on Room Air, at Rest %:
O2 Sat on Room Air, During
Exertion %:
O2 Sat on Oxygen with Exertion %
demonstrates improvement (above 88%):
O2 Device:
O2 Flowrate (L/Min) Setting:
INDICATIONS for Ordering
Oxygen: Must enter Lung Disease or Hypoxia
Related Symptoms:
if (answer = Lung Disease
Diagnosis)
INDICATIONS for Ordering
Oxygen: Must enter Lung Disease Diagnosis
or Hypoxia Related Symptoms - Lung
Disease Diagnosis:
if (answer = Hypoxia Related
Symptoms)
Hypoxia Related Symptoms:
if (answer = Nebulizer)
Nebulizer Med:
if (answer = Albuterol)
Albuterol dose:
if (answer = Xopenex)
Xopenex dose:
if (answer = Mucomyst)
Mucomyst dose:
if (answer = Atrovent)

Atrovent dose:
 INDICATIONS for Ordering
 Nebulizer: Must enter Lung Disease or
 Hypoxia Related Symptoms:
 if (answer = Lung Disease
 Diagnosis)
 INDICATIONS for Ordering
 Nebulizer: Must enter Lung Disease
 Diagnosis or Hypoxia Related Symptoms -
 Lung Disease Diagnosis:
 if (answer = Hypoxia Related
 Symptoms)
 Hypoxia Related Symptoms:
 if (answer = Trach supplies)
 Type:
 Size of tube:
 if (answer = Home ventilator)
 Home ventilator settings:
 if (answer = CPAP)
 Pressure:
 if (answer = BIPAP)
 IPAP:
 EPAP:
 if (answer = O2 Bleed in Rate)
 Liter flow:
 if (answer = Portable O2 Generator)
 Continuous or PRN Oxygen:
 O2 Duration:
 O2 Sat on Room Air, at Rest %:
 O2 Sat on Room Air, During
 Exertion %:
 O2 Sat on Oxygen with Exertion %
 demonstrates improvement (above 88%):
 O2 Device:
 O2 Flowrate (L/Min) Setting:
 INDICATIONS for Ordering
 Oxygen: Must enter Lung Disease or Hypoxia
 Related Symptoms:
 if (answer = Lung Disease
 Diagnosis)
 INDICATIONS for Ordering
 Oxygen: Must enter Lung Disease Diagnosis
 or Hypoxia Related Symptoms - Lung
 Disease Diagnosis:
 if (answer = Hypoxia Related
 Symptoms)
 Hypoxia Related Symptoms:
 if (answer = Hospital Bed)
 Hospital Bed:
 if (answer = Gel Overlay)
 Indicate which of the following
 conditions describe the patient. Answer all
 that apply:
 if (answer = Alternating Pressure
 Mattress)
 Indicate which of the following
 conditions describe the patient. Answer all
 that apply:
 if (answer = Low Air Loss Mattress)
 Additional Medical Information -
 select all that apply:
 if (answer = Semi-Electric Hospital
 Bed with Split Siderails)
 Pressure ulcer - check all that

apply:
 if (answer = Semi-Electric Hospital Bed with Full Rails)
 Pressure ulcer - check all that apply:
 if (answer = Other Equipment (specify))
 Other Equipment:
 if (answer = Other (specify))
 Other:
 if (answer = Diabetic supplies)
 Diabetic supplies:
 Face-to-Face Date:
 Clinical Findings:
 if (answer = Other:)
 Other Clinical Findings:
 Special Instructions:

Phase of Care:

Comments:

Consult to Social Work

Reason for Consult:

Defaults

Available Buttons

[Adoption] [Chemical Dependency]
 [Deaf] [Discharge Planning] [Fetal Demise]
 [Discharge Placement] [Hospice Referral]
 [SNF] [Suspected Abuse] [Suspected Domestic Violence]
 [Teen Pregnancy] [Other Specify]

Additional Questions:

if (answer = Other Specify)
 Specify:

Phase of Care:

Comments:

Consult PT eval and treat

Reasons for referral to Physical Therapy (mark all applicable):

Defaults

Available Buttons

[Unsuccessful mobility attempts with Nursing personnel]
 [Post Neuromuscular or Musculoskeletal Surgery Care.]
 [New functional deficits, not expected to spontaneously recover with medical modalities]
 [History of recent falls (non-syncopal)]
 [Recommendations for post-acute hospital placement] [Other]

Additional Questions:

if (answer = Other)
 Specify:

Are there any restrictions for positioning or mobility?

Additional Questions:

if (answer = Yes)
 Limit:
 if (answer = sitting to)
 Specify:
 if (answer = standing to)
 Specify:
 if (answer = limb/joint bend)
 Specify:
 if (answer = elevate limb)
 Specify:
 if (answer = other)
 Specify:

Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):

Weight Bearing Status:

[LLE] [RLE] [LUE] [RUE]

Additional Questions:

if (answer = LLE)
LLE Limitation:
if (answer = RLE)
RLE Limitation:
if (answer = LUE)
LUE Limitation:
if (answer = RUE)
RUE Limitation:

Phase of Care:

Comments:

Consult PT wound care

Defaults

Available Buttons

Special Instructions:

Location of Wound?

[Abdomen] [Buttocks] [Groin] [Lower Extremity] [Sacral] [Upper Extremity] [Other Specify]

Additional Questions:

if (answer = Lower Extremity)
Lower Extremity:
if (answer = Upper Extremity)
Upper Extremity:
if (answer = Other Specify)
Other:

Phase of Care:

Comments:

Consult OT eval and treat

Defaults

Available Buttons

Reason for referral to Occupational Therapy (mark all that apply):

[Decline in Activities of Daily Living performance from baseline (bathing, dressing, toileting, grooming)] [Post-operative instruction or treatment necessary prior to discharge] [Decrease in functional cognition from patient's baseline] [Needs home safety recommendations prior to discharge] [Increased falling (non-syncopal).] [Patient lives alone and is deconditioned (post-surgery or extensive hospital stay)] [Other]

Additional Questions:

if (answer = Other)
Specify:

Are there any restrictions for positioning or mobility?

Additional Questions:

if (answer = Yes)
Limit:
if (answer = sitting to)
Specify:
if (answer = standing to)
Specify:
if (answer = limb/joint bend)
Specify:
if (answer = elevate limb)
Specify:
if (answer = other)
Specify:

Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):

Weight Bearing Status:

[LLE] [RLE] [LUE] [RUE]

Additional Questions:

if (answer = LLE)

LLE Limitation:
if (answer = RLE)
RLE Limitation:
if (answer = LUE)
LUE Limitation:
if (answer = RUE)
RUE Limitation:

Phase of Care:

Comments:

Consult to Nutrition Services

Defaults

Available Buttons

Reason For Consult?

[MD order Diet Consult] [Transplant Evaluation] [Diet Education] [Other (Specify)]

Additional Questions:

if (answer = Other (Specify))
Specify:

Purpose/Topic:

Phase of Care:

Comments:

Consult to Spiritual Care

Defaults

Available Buttons

Reason for consult?

[Spiritual Support] [End of Life Support] [Pre-Surgical Prayer] [Catholic-Holy Communion] [Catholic Priest] [Advance Directive] [Other Specify]

Additional Questions:

if (answer = Catholic Priest)
Reason for contacting Catholic Priest:
if (answer = Other Specify)
Specify:
if (answer = Advance Directive)
Is the patient alert and oriented?
if (answer = No)
No, Patient does not have capacity:
if (answer = Other Specify)
Specify:

Phase of Care:

Comments:

Consult to Speech Language Pathology

Defaults

Available Buttons

Priority:

Routine

[Routine]

Frequency:

Once

[Once]

Reason for consult:

[Dysphagia] [Aphasia] [Dysarthria] [Communication] [Speaking Valve] [Cognition] [Other]

Additional Questions:

if (answer = Other)
Reason for SLP?

Comments:

Phase of Care:

Consult to Wound Ostomy Care nurse

Defaults

Available Buttons

Reason for consult:

[Pre-Operative Instruction] [Pre-Operative Stoma Site Selection] [Post-Operative Ostomy Care Teaching] [Ostomy] [Fistula] [Tube Management] [Continence Care] [PUPP Assessment/Evaluation]

Additional Questions:

if (answer = Ostomy)
Type of Ostomy:
if (answer = Other)
Specify:

Reason for consult:

[Ostomy] [Fistula/Tube management requiring pouch] [Vascular ulceration]

| | | |
|-----------------------|--|--|
| | | [Arterial ulcers] [Pressure injury] [Non-healing chronic wound] [Diabetic foot] |
| Additional Questions: | | if (answer = Ostomy) Status: Ostomy type: |
| Reason for consult: | | [Ostomy] [Wound] [Fistula] [Continenence] [Tube management] |
| Additional Questions: | | if (answer = Ostomy) Ostomy type: if (answer = Wound) Wound type: if (answer = Other) Specify: |
| Reason for consult: | | [Ostomy] |
| Additional Questions: | | if (answer = Ostomy) Status: Ostomy type: |
| Consult for NPWT: | | [Negative pressure wound therapy] |
| Additional Questions: | | if (answer = Negative pressure wound therapy) Pressure (mmHg): Therapy Settings: if (answer = Other) Specify: if (answer = Dynamic Pressure Control) DCP Ratio: Intensity: Foam Type: Type of Wound: if (answer = Other) Specify: |
| Reason for consult: | | [Pre-Operative Instruction] [Pre-Operative Stoma Site Selection] [Post-Operative Ostomy Care Teaching] [Ostomy] [Fistula] [Tube Management] [Continenence Care] [PUPP Assessment/Evaluation] |
| Additional Questions: | | if (answer = Ostomy) Type of Ostomy: if (answer = Other) Specify: |
| Phase of Care: | | |
| Comments: | | |

Consult to Respiratory Therapy

Defaults

Available Buttons

| | |
|---------------------|--|
| Reason for Consult? | |
| Phase of Care: | |
| Comments: | |

Other