## Labor Admission Only Appears If: **HM SB INPATIENT**

Default Phase of Care: L&D Pre-Delivery

### General

#### Phase of Care

This order must be checked to allow group discontinuation of pre-delivery orders by nursing during post partum phase of care.

#### [X] Discontinue pre-delivery orders

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Once ]**
Order comments:
Scheduling Instructions:

#### Admission Orders (Selection Required) Only Appears If: **SB ACTIVE OR COMPLETED OB ADMIT ORDER**

Do not use Outpatient Observation Services Under General Supervision order for patients who are receiving Outpatient TRIAGE services.

#### (X) Admit to L&D

Diagnosis:
Order comments:

##### Questions:

If HM NOT Ed Obs Unit Login is satisfied:
Admitting Physician:
Bed request comments:

#### Code Status Only Appears If: **SB PHYSICIAN ONLY NO RESIDENTS OR FELLOWS**

@CERMSGREFRESHOPT(674511:21703,,,1)@

#### [X] Full code

Process Instructions:
The Code Status and Treatment Restrictions are two SEPARATE sets of physician's orders. For further guidance, please click on the link below: Guidance for Code Status & Treatment Restrictions
Examples of Code Status are Full Code, DNR, or Modified Code. An example of a Treatment Restriction is avoidance of blood transfusion in a Jehovah's Witness patient.
If the Legal Surrogate is the Primary Physician, consider ordering a Biomedical Ethics Consult PRIOR to placing this order. A Concurring Physician is required to second sign the order when the Legal Surrogate is the Primary Physician.

##### Questions:

Code Status decision reached by: **[ Patient by means of Oral Directive ]** [ Patient ] [ Patient by means of Directive ] [ Legal Surrogate ]

##### Possible Cascading Questions:

If (answer is Legal Surrogate):
Name of Surrogate:
Surrogate Relation:
If (answer is 6. Primary Physician with Concurring Physician):
A Biomedical Ethics Consult is recommended.
I will consult with a second physician, listed below, to co-sign this order.
If (answer is 5. Nearest living relative (specify)):
Nearest living relative:

#### [ ] DNR (Do Not Resuscitate) (Selection Required)

##### [ ] DNR (Do Not Resuscitate)

Process Instructions:
The Code Status and Treatment Restrictions are two SEPARATE sets of physician's orders. For further guidance, please click on the link below: Guidance for Code Status & Treatment Restrictions
Examples of Code Status are Full Code, DNR, or Modified Code. An example of a Treatment Restriction is avoidance of blood transfusion in a Jehovah's Witness patient.
If the Legal Surrogate is the Primary Physician, consider ordering a Biomedical Ethics Consult PRIOR to placing this order. A Concurring Physician is required to second sign the order when the Legal Surrogate is the Primary Physician.

##### Questions:

If HM ORD INTERPRETER NEEDED YES is satisfied:
Did the patient/surrogate require the use of an interpreter? [ Yes ] [ No ]
If HM ORD INTERPRETER NEEDED NO OR NOT ANSWERED is satisfied:
Did the patient/surrogate require the use of an interpreter? [ Yes ] [ No ]
Does patient have decision-making capacity? [ Yes ] [ No ]

Possible Cascading Questions:

If (answer is Yes):
Is the patient's death imminent?
If (answer is Yes):
Code Status decision reached by:
If (answer is Physician per criteria):
I have notified/made reasonably diligent effort to notify the patient/family/legal representative that a DNR/Modified Code order has been placed in the patient's medical record.
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is DNR/Modified Code medically appropriate?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is DNR/Modified Code NOT contrary to patient's/surrogate's direction?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is Patient imminently dying, regardless of provision of CPR?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
If (answer is No):
Code Status decision reached by:
If (answer is Patient by means of Oral Directive):
Witness 1 Name:
Witness 2 Name:
If (answer is No):
Is the patient's death imminent?
If (answer is Yes):
Code Status decision reached by:
If (answer is Physician per criteria):
I have notified/made reasonably diligent effort to notify the patient/family/legal representative that a DNR/Modified Code order has been placed in the patient's medical record.
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is DNR/Modified Code medically appropriate?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is DNR/Modified Code NOT contrary to patient's/surrogate's direction?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is Patient imminently dying, regardless of provision of CPR?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
If (answer is Legal Surrogate):
Name of Surrogate:
Surrogate Relation:
If (answer is 6. Primary Physician with Concurring Physician):
A Biomedical Ethics Consult is recommended.
I will consult with a second physician, listed below, to co-sign this order.
If (answer is 5. Nearest living relative (specify)):
Nearest living relative:
If (answer is No):
Code Status decision reached by:
If (answer is Legal Surrogate):
Name of Surrogate:
Surrogate Relation:
If (answer is 6. Primary Physician with Concurring Physician):
A Biomedical Ethics Consult is recommended.
I will consult with a second physician, listed below, to co-sign this order.
If (answer is 2. Spouse) Or (answer is 3. Adult Child/Children) Or (answer is 4. Parent(s)) Or (answer is 1. Legal Guardian or Agent):
Concurring Physician (Optional):
If (answer is 5. Nearest living relative (specify)):
Nearest living relative:
Concurring Physician (Optional):

[ ] Consult to Palliative Care Service (Selection Required) Only Appears If: **SB IP ORDERSET NOT HMSTC**

[X] Consult to Palliative Care Service

Order comments:

Questions:

Priority: [ 24 Hrs. ] [ Same Day ] [ ASAP ]
Reason for Consult? [ Assistance with advance directives ] [ Assistance with clarification of goals of care ] [ Assistance with withdrawal of life prolonging interventions ] [ Hospice discussion ] [ Facilitation of Family Care Conference ] [ Pain ] [ Psychosocial support ] [ Symptom management ] [ End of Life Care Discussion ] [ Introductions/Established Care ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Specify:

Order? [ Make recommendations only ] [ Make recommendations and write orders ]
Name of referring provider:
Enter call back number:

[ ] Consult to Social Work

Priority: **[ Routine ]** [ STAT ]
Order comments:

Questions:

Reason for Consult: [ Adoption ] [ Chemical Dependency ] [ Deaf ] [ Discharge Planning ] [ Fetal Demise ] [ Discharge Placement ] [ Hospice Referral ] [ SNF ] [ Suspected Abuse ] [ Suspected Domestic Violence ] [ Teen Pregnancy ] [ Human Trafficking ] [ Dialysis Placement ] [ SDOH ] [ Other Specify ]

Possible Cascading Questions:

If (answer is Other Specify):
Specify:
If (answer is Hospice Referral):
Evaluate for:
If (answer is SDOH):
Specify for SDOH:

[ ] Modified Code

Process Instructions:
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Examples of Code Status are Full Code, DNR, or Modified Code. An example of a Treatment Restriction is avoidance of blood transfusion in a Jehovah's Witness patient.
If the Legal Surrogate is the Primary Physician, consider ordering a Biomedical Ethics Consult PRIOR to placing this order. A Concurring Physician is required to second sign the order when the Legal Surrogate is the Primary Physician.

Questions:

If HM ORD INTERPRETER NEEDED NO OR NOT ANSWERED is satisfied:
Did the patient/surrogate require the use of an interpreter? [ Yes ] [ No ]
If HM ORD INTERPRETER NEEDED YES is satisfied:
Did the patient/surrogate require the use of an interpreter? [ Yes ] [ No ]
Does patient have decision-making capacity? [ Yes ] [ No ]

Possible Cascading Questions:

If (answer is Yes):
Is the patient's death imminent?
If (answer is Yes):
Code Status decision reached by:
If (answer is Physician per criteria):
I have notified/made reasonably diligent effort to notify the patient/family/legal representative that a DNR/Modified Code order has been placed in the patient's medical record.
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is DNR/Modified Code medically appropriate?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is DNR/Modified Code NOT contrary to patient's/surrogate's direction?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is Patient imminently dying, regardless of provision of CPR?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
If (answer is No):
Code Status decision reached by:
If (answer is Patient by means of Oral Directive):
Witness 1 Name:
Witness 2 Name:
If (answer is No):
Is the patient's death imminent?
If (answer is Yes):
Code Status decision reached by:
If (answer is Physician per criteria):
I have notified/made reasonably diligent effort to notify the patient/family/legal representative that a DNR/Modified Code order has been placed in the patient's medical record.
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.

Is DNR/Modified Code medically appropriate?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is DNR/Modified Code NOT contrary to patient's/surrogate's direction?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
Is Patient imminently dying, regardless of provision of CPR?
If (answer is No):
Order CANNOT Proceed with answer "No". You will not be allowed to Sign this order.
If (answer is Legal Surrogate):
Name of Surrogate:
Surrogate Relation:
If (answer is 6. Primary Physician with Concurring Physician):
A Biomedical Ethics Consult is recommended.
I will consult with a second physician, listed below, to co-sign this order.
If (answer is 5. Nearest living relative (specify)):
Nearest living relative:
If (answer is No):
Code Status decision reached by:
If (answer is Legal Surrogate):
Name of Surrogate:
Surrogate Relation:
If (answer is 6. Primary Physician with Concurring Physician):
A Biomedical Ethics Consult is recommended.
I will consult with a second physician, listed below, to co-sign this order.
If (answer is 2. Spouse) Or (answer is 3. Adult Child/Children) Or (answer is 4. Parent(s)) Or (answer is 1. Legal Guardian or Agent):
Concurring Physician (Optional):
If (answer is 5. Nearest living relative (specify)):
Nearest living relative:
Concurring Physician (Optional):

Modified Code restrictions: [ No Intubation ] [ No Chest Compressions ] [ No Electrical Shocks ] [ No Resuscitative Drugs ]

[ ] Treatment Restrictions ((For use when a patient is NOT in a cardiopulmonary arrest))

Process Instructions:
Treatment Restrictions is NOT a Code Status order. It is NOT a Modified Code order. It is strictly intended for Non Cardiopulmonary situations.
The Code Status and Treatment Restrictions are two SEPARATE sets of physician's orders. For further guidance, please click on the link below: Guidance for Code Status & Treatment Restrictions
Examples of Code Status are Full Code, DNR, or Modified Code. An example of a Treatment Restriction is avoidance of blood transfusion in a Jehovah's Witness patient.
If the Legal Surrogate is the Primary Physician, consider ordering a Biomedical Ethics Consult PRIOR to placing this order. A Concurring Physician is required to second sign the order when the Legal Surrogate is the Primary Physician.

Questions:

I understand that if the patient is NOT in a cardiopulmonary arrest, the selected treatments will NOT be provided. I understand that all other unselected medically indicated treatments will be provided. [ Yes ]
Treatment Restriction decision reached by: [ Patient ] [ Patient by means of Directive ] [ Legal Surrogate ]

Possible Cascading Questions:

If (answer is Legal Surrogate):
Name of Surrogate:
Surrogate Relation:
If (answer is 6. Primary Physician with Concurring Physician):
A Biomedical Ethics Consult is recommended.
I will consult with a second physician, listed below, to co-sign this order.
If (answer is 5. Nearest living relative (specify)):
Nearest living relative:

Specify Treatment Restrictions: [ No Intubation and mechanical ventilation ] [ No Re-intubation ] [ No Non-invasive ventilation ] [ No Electrical shock/cardioversion ] [ No Pacemaker ] [ No Pressors/Inotropes/Chronotropes ] [ No Increases in Pressors/Inotropes/Chronotropes ] [ No Invasive hemodynamic monitoring ] [ No Dialysis ] [ No Antibiotics ] [ No Infusion of blood products ] [ No Intravenous fluids ] [ No Artificial nutrition/artificial hydration ] [ No Intensive care unit ] [ Other Treatment Restrictions ]

Possible Cascading Questions:

If (answer is Other Treatment Restrictions):
Specify Other Treatment Restrictions:

Isolation

[ ] Airborne isolation status (Selection Required)

[X] Airborne isolation status

Order comments:

Process Instructions:
A requisition for an isolation cart will be sent to Central Supply when this order is signed.
If patient is transferred and a new cart is needed, please use "Request for central supply equipment - miscellaneous" order to obtain replacement cart.

[ ] Mycobacterium tuberculosis by PCR - If you suspect Tuberculosis, please order this test for rapid diagnostics.
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ Timed ]
Specimen Type:
Specimen Source:
Order comments:

[ ] Contact isolation status
Order comments:
Process Instructions:
A requisition for an isolation cart will be sent to Central Supply when this order is signed.
If patient is transferred and a new cart is needed, please use "Request for central supply equipment - miscellaneous" order to obtain replacement cart.

[ ] Droplet isolation status
Order comments:
Process Instructions:
A requisition for an isolation cart will be sent to Central Supply when this order is signed.
If patient is transferred and a new cart is needed, please use "Request for central supply equipment - miscellaneous" order to obtain replacement cart.

[ ] Enteric isolation status
Order comments:
Process Instructions:
A requisition for an isolation cart will be sent to Central Supply when this order is signed.
If patient is transferred and a new cart is needed, please use "Request for central supply equipment - miscellaneous" order to obtain replacement cart.

## Precautions

[ ] Aspiration precautions
Priority: **[ Routine ]** [ STAT ]
Order comments:

[ ] Fall precautions
Priority: **[ Routine ]** [ STAT ]
Order comments: On Admission and every 8 hours

Questions:
Increased observation level needed: [ Yes ] [ No ]

Possible Cascading Questions:
If (answer is Yes):
Level:
For:
Time:

[ ] Latex precautions
Priority: **[ Routine ]** [ STAT ]
Order comments:

[ ] Seizure precautions
Priority: **[ Routine ]** [ STAT ]
Order comments:

Questions:
Increased observation level needed: [ Yes ] [ No ]

Possible Cascading Questions:
If (answer is Yes):
Level:
For:
Time:

## Common Present on Admission Diagnosis

[ ] Acidosis
[ ] Acute Post-Hemorrhagic Anemia

[ ] Acute Renal Failure
[ ] Acute Respiratory Failure
[ ] Acute Thromboembolism of Deep Veins of Lower Extremities
[ ] Anemia
[ ] Bacteremia
[ ] Bipolar disorder, unspecified
[ ] Cardiac Arrest
[ ] Cardiac Dysrhythmia
[ ] Cardiogenic Shock
[ ] Decubitus Ulcer
[ ] Dementia in Conditions Classified Elsewhere
[ ] Disorder of Liver
[ ] Electrolyte and Fluid Disorder
[ ] Intestinal Infection due to Clostridium Difficile
[ ] Methicillin Resistant Staphylococcus Aureus Infection
[ ] Obstructive Chronic Bronchitis with Exacerbation
[ ] Other Alteration of Consciousness
[ ] Other and Unspecified Coagulation Defects
[ ] Other Pulmonary Embolism and Infarction
[ ] Phlebitis and Thrombophlebitis
[ ] Protein-calorie Malnutrition
[ ] Psychosis, unspecified psychosis type
[ ] Schizophrenia Disorder
[ ] Sepsis
[ ] Septic Shock
[ ] Septicemia
[ ] Type II or Unspecified Type Diabetes Mellitus with Mention of Complication, Not Stated as Uncontrolled
[ ] Urinary Tract Infection, Site Not Specified
[ ] Present on Admission-History of preterm premature rupture of membranes

Panel Orders

OB Panel Orders

[ ] Magnesium Sulfate OB Panel (Selection Required)

[X] Vital Signs (Selection Required)

[X] Neuro checks

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Until Discontinued ]** [ Q15 Min ] [ Q30 Min ] [ Q1H ] [ Q2H ] [ Q4H ]
Starting: Today, At: N
Order comments: Every 5 minutes during initiation of loading dose, then every 15 minutes x 3, then every 30 minutes x 2, then every 1 hour, or as based on patient acuity/physician order. Notify physician for decrease or change in level of consciousness.
Scheduling Instructions:

[X] Pulse oximetry

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Q2H ]** [ Once ] [ Daily ] [ Q PM ] [ Continuous ] [ HS only ]
Order comments: Monitor continuously throughout loading dose and then spot check every 2 hours while assessing maternal respiratory effort and breath sounds. Notify MD if SaO2 is less than 94%

Questions:

Current FIO2 or Room Air: [ Current FIO2 ] [ Room Air ]

[X] Vital signs - T/P/R/BP

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Q5 Min ]** [ Q1H ] [ Q2H ] [ Q4H ] [ Per Unit Protocol ]
Order comments: Prior to administration of Magnesium Sulfate. Every 5 minutes during loading dose, then every 30 minutes until stable, then hourly 8 times then, if stable, every 4 hours.
Scheduling Instructions:

[X] Nursing (Testing) (Selection Required)

[X] Assess breath sounds

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Q2H ]** [ Once ] [ Q3H ] [ Q4H ] [ Q Shift ] [ Daily ]
Order comments: Monitor maternal respiratory effort and breath sounds every 2 hours. Notify physician for shortness of breath or tightness

in chest.
Phase of Care:

Questions:
Assess: breath sounds

[X] Assess for Magnesium Toxicity
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Q15 Min ]** [ Once ] [ Q3H ] [ Q4H ] [ Q Shift ] [ Daily ]
Starting: Today
Order comments: Monitor and document. Acquire a baseline measurement prior to infusion therapy, then assess deep tendon reflex's (DTR), level of consciousness (LOC) and orientation, clonus, headache, visual disturbances, nausea/vomiting, and epigastric pain every 15 minutes times 1 hour, then every 30 minutes times 1 hour. Following the first two hours of magnesium infusion monitor DTR's every 2 hours or per physician order. Notify physician for decreased or absent deep tendon reflexes.
Scheduling Instructions:

[ ] Assess for PreEclampsia
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Once ]** [ Q3H ] [ Q4H ] [ Q Shift ] [ Daily ]
Order comments: Monitor for Non Remitting Headache, Visual Disturbances, Epigastric Pain, and Clonus every 15 min times 1 hour, then every 30 minutes times 1 hour during magnesium bolus then every 2 hours while on magnesium sulfate.
Scheduling Instructions:

Questions:
Assessment to Perform: [ Cranial Nerves ] [ Glasgow Coma Scale ] [ Level of Consciousness ] [ Level of Sedation ] [ Pupils ] [ Spinal exams ]

Possible Cascading Questions:
If (answer is Spinal exams):
Perform:
Area:

[ ] Daily weights
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Daily ]**
Order comments:
Scheduling Instructions:

[ ] Toileting - Bedside commode
Priority: **[ Routine ]**
Frequency: **[ Until Discontinued ]** [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments:
Scheduling Instructions:

Questions:
Specify: [ Bathroom privileges ] [ Bedside commode ] [ Encourage frequent voiding ]

Possible Cascading Questions:
If (answer is Bathroom privileges) Or (answer is Bedside commode):
Additional modifier:

[X] Strict intake and output
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Q1H ]** [ Q4H ] [ Q8H ]
Order comments:
Scheduling Instructions:

[X] Limit total IV fluid intake to 125 cc/hr
Priority: **[ Routine ]**
Frequency: [ Once ] **[ Until Discontinued ]**
Starting: Today, At: N
Order comments:
Scheduling Instructions:

[ ] Insert and maintain Foley (Selection Required)
[X] Insert Foley catheter
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Once ]** [ Q4H ] [ Q Shift ] [ Daily ]
Order comments: Foley catheter may be removed per nursing protocol.

Scheduling Instructions:

Questions:

Type: [ 2 Way ] [ 3 Way ] [ Coude ] [ Temperature Sensing ]
Size: [ 14 French ] [ 16 French ] [ 18 French ]
Urinometer needed: [ Yes ] [ No ]
Indication: [ Comfort ] [ Hemodynamic Monitoring ] [ Obstruction ] [ Retention ] [ Urologic ] [ Surgery ]

[X] Foley Catheter Care

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Until Discontinued ]** [ Daily ]
Starting: Today, At: N
Order comments:
Scheduling Instructions:

Questions:

Orders: [ to gravity ] [ to leg bag ] [ flush ] [ flush until clear ] [ Site care Qshift & PRN ] **[ Maintain ]** [ Irrigate urinary catheter PRN ] [ Do not manipulate ]

[ ] Activity (Selection Required)

[ ] Strict bed rest

Priority: **[ Routine ]**
Frequency: **[ Until Discontinued ]** [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments:
Scheduling Instructions:

[X] Bed rest with bathroom privileges

Priority: **[ Routine ]**
Frequency: **[ Until Discontinued ]** [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments:
Scheduling Instructions:

Questions:

Bathroom Privileges: **[ with bathroom privileges ]** [ with bedside commode ]

[ ] Bed rest with bathroom privileges for BM only

Priority: **[ Routine ]**
Frequency: **[ Until Discontinued ]** [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments: For bowel movement only
Scheduling Instructions:

Questions:

Bathroom Privileges: **[ with bathroom privileges ]** [ with bedside commode ]

[ ] Diet (Selection Required)

[ ] NPO

Process Instructions: An NPO order without explicit exceptions means nothing can be given orally to the patient.
Frequency: [ Effective Midnight ] **[ Effective Now ]** [ Effective 0500 (Breakfast) ] [ Effective 1000 (Lunch) ] [ Effective 1400 (Dinner) ] [ Effective _____ ]
Starting: Today, At: N
Order comments:

Questions:

NPO: [ Except meds ] [ Except Ice chips ] [ Except Sips with meds ] [ Except Sips of clear liquids ]
Pre-Operative fasting options:

Possible Cascading Questions:

If (answer is Other):
Specify:

[X] NPO with ice chips

Process Instructions: An NPO order without explicit exceptions means nothing can be given orally to the patient.
Frequency: [ Effective Midnight ] **[ Effective Now ]** [ Effective 0500 (Breakfast) ] [ Effective 1000 (Lunch) ] [ Effective 1400 (Dinner) ] [ Effective _____ ]

Starting: Today, At: N
Order comments: 1/2 cup per hour

Questions:

NPO: [ Except meds ] **[ Except Ice chips ]** [ Except Sips with meds ] [ Except Sips of clear liquids ]
Pre-Operative fasting options:

Possible Cascading Questions:

If (answer is Other):
Specify:

[ ] Diet - Clear liquids

Frequency: **[ Effective Now ]** [ Effective 0500 (Breakfast) ] [ Effective 1000 (Lunch) ] [ Effective 1400 (Dinner) ] [ Effective Midnight ] [ Effective _____ ] [ Effective tomorrow ]
Starting: Today, At: N
Order comments:

Questions:

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 ] [ IDDSI/Dysphagia ] [ Bariatric ] [ Other Diabetic/Cal ] [ Other Protein ]

Possible Cascading Questions:

If (answer is IDDSI/Dysphagia):
IDDSI Solid Consistency:
If (answer is Other Diabetic/Cal):
Diabetic/Calorie:
If (answer is Other Protein):
Protein:
If (answer is Bariatric):
Bariatric:

Advance Diet as Tolerated? [ Yes ] [ No ]

Possible Cascading Questions:

If (answer is Yes):
Target Diet:
Advance target diet criteria:

IDDSI Liquid Consistency: [ Level 1 Slightly Thick ] [ Level 2 Mildly Thick ] [ Level 3 Moderately Thick ] [ Level 4 Extremely Thick ]
Fluid Restriction: [ Fluid Restriction 500 ml ] [ Fluid Restriction 750 ml ] [ Fluid Restriction 1000 ml ] [ Fluid Restriction 1200 ml ] [ Fluid Restriction 1500 ml ] [ No Fluids ]
If HM ORD NOT ACTIVE LUNG TRANSPLANT EPISDOE is satisfied:
Foods to Avoid:
Cultural/Special: [ Kosher ] [ Middle Eastern ] [ Vegetarian ] [ Gluten Free ] [ Vegan ]
Other Options: [ Finger Foods ] [ Safety Tray ]

[X] Notify (Selection Required)

[X] Notify Physician for validated vitals:

Priority: Routine
Frequency: **[ Until Discontinued ]** [ Once ]
Starting: Today, At: N
Order comments: For validated vital signs and for urine output less than 30 milliliters per hour

Questions:

Temperature greater than: 100.3
Temperature less than:
If HM ORD POST LVO AND POST ALTEPLASE NOT ACTIVE is satisfied:
Systolic BP greater than:
If HM ORD POST LVO AND POST ALTEPLASE NOT ACTIVE is satisfied:
Systolic BP less than:
If HM ORD POST LVO AND POST ALTEPLASE NOT ACTIVE is satisfied:
Diastolic BP greater than:
If HM ORD POST LVO AND POST ALTEPLASE NOT ACTIVE is satisfied:
Diastolic BP less than:
If HM ORD POST LVO AND POST ALTEPLASE NOT ACTIVE is satisfied:
MAP less than:
Heart rate greater than (BPM):
Heart rate less than (BPM):
Respiratory rate greater than:
Respiratory rate less than: 10

SpO2 less than: 95

[X] Notify Physician for magnesium

Priority: Routine
Frequency: **[ Until Discontinued ]** [ Once ]
Starting: Today, At: N
Order comments:
Scheduling Instructions:

Questions:

BUN greater than:
Creatinine greater than:
Glucose greater than:
Glucose less than:
Hct less than:
Hgb less than:
LDL greater than:
Magnesium greater than (mg/dL): 8
Magnesium less than (mg/dL): 4
Platelets less than:
Potassium greater than (mEq/L):
Potassium less than (mEq/L):
PT/INR greater than:
PT/INR less than:
PTT greater than:
PTT less than:
Serum Osmolality greater than:
Serum Osmolality less than:
Sodium greater than:
Sodium less than:
WBC greater than:
WBC less than:
Other Lab (Specify):

[X] IV Fluids (Selection Required)

[X] lactated ringers (LR) or sodium chloride 0.9% (NS) infusion (Selection Required)

Due to IV shortage, LR or NS will be administered based on availability

lactated ringer's infusion

Dose: [ 50 mL/hr ] **[ 75 mL/hr ]** [ 100 mL/hr ] [ 125 mL/hr ]
Route: **[ intravenous ]**
Frequency: **[ Once ]** [ Continuous ]
Admin Instructions: Due to IV shortage, LR or NS will be administered based on availability
Priority: **[ Routine ]**

Or

sodium chloride 0.9 % infusion

Dose: 75 mL/hr
Route: **[ intravenous ]**
Frequency: **[ Once ]** [ Continuous ]
Admin Instructions: Due to IV shortage, LR or NS will be administered based on availability
Priority: **[ Routine ]**

[X] Magnesium Sulfate (Selection Required)

( ) Magnesium Sulfate 6 gm Loading and Maintenance Infusion (Selection Required)

DISCONTINUE INFUSION AND CALL PROVIDER IF SYMPTOMS OF MAGNESIUM TOXICITY ARE PRESENT.

[X] Monitor for signs/symptoms of Magnesium Toxicity: decreased or absent DTRs, decreased or changes in level of consciousness, decreased respiratory rate (less than 10 breaths/minute), oliguria (less than 30 mililiters/hour), shortness of breath or tightness in chest

Priority: **[ Routine ]**
Frequency: [ Once ] **[ Until Discontinued ]**
Starting: Today, At: N
Order comments:
Scheduling Instructions:

[X] magnesium sulfate 6 gm IV Loading Dose + Maintenance infusion (Selection Required)

Loading Dose - magnesium sulfate 6 grams IV bolus from bag

Dose: [ 4 g ] **[ 6 g ]**
Route: **[ intravenous ]**

Frequency: **[ Once ]**
Admin Instructions: Loading Dose - Bolus from Bag
Priority: **[ Routine ]**

Followed by

Maintenance Dose - magnesium sulfate IV
Dose: [ 1 g/hr ] [ 2 g/hr ] [ 3 g/hr ]
Route: **[ intravenous ]**
Frequency: **[ Continuous ]**
Starting: 30 Minutes after signing
Admin Instructions:
Priority: **[ Routine ]**

( ) magnesium sulfate 4 gm Loading and Maintenance Infusion (Selection Required)
DISCONTINUE INFUSION AND CALL PROVIDER IF SYMPTOMS OF MAGNESIUM TOXICITY ARE PRESENT.

[X] Monitor for signs/symptoms of Magnesium Toxicity: decreased or absent DTRs, decreased or changes in level of consciousness, decreased respiratory rate (less than 10 breaths/minute), oliguria (less than 30 mililiters/hour), shortness of breath or tightness in chest
Priority: **[ Routine ]**
Frequency: [ Once ] **[ Until Discontinued ]**
Starting: Today, At: N
Order comments:
Scheduling Instructions:

[X] magnesium sulfate 4 gm IV Loading Dose + Maintenance infusion (Selection Required)
Loading Dose - magnesium sulfate 4 grams IV bolus from bag
Dose: **[ 4 g ]** [ 6 g ]
Route: **[ intravenous ]**
Frequency: **[ Once ]**
Admin Instructions: Loading Dose - Bolus from Bag
Priority: **[ Routine ]**

Followed by

Maintenance Dose - magnesium sulfate IV
Dose: [ 1 g/hr ] [ 2 g/hr ] [ 3 g/hr ]
Route: **[ intravenous ]**
Frequency: **[ Continuous ]**
Starting: 30 Minutes after signing
Admin Instructions:
Priority: **[ Routine ]**

( ) Magnesium Sulfate Maintenance Only (Selection Required)
DISCONTINUE INFUSION AND CALL PROVIDER IF SYMPTOMS OF MAGNESIUM TOXICITY ARE PRESENT.

[X] Monitor for signs/symptoms of Magnesium Toxicity: decreased or absent DTRs, decreased or changes in level of consciousness, decreased respiratory rate (less than 10 breaths/minute), oliguria (less than 30 mililiters/hour), shortness of breath or tightness in chest
Priority: **[ Routine ]**
Frequency: [ Once ] **[ Until Discontinued ]**
Starting: Today, At: N
Order comments:
Scheduling Instructions:

[X] magnesium sulfate in water 20 gram/500 mL (4 %) infusion
Dose: [ 1 g/hr ] **[ 2 g/hr ]** [ 3 g/hr ] [ 4 g/hr ]
Route: **[ intravenous ]**
Frequency: **[ Continuous ]**
Admin Instructions:
Priority: **[ Routine ]**

[ ] Corticosteroids (Selection Required)
( ) betamethasone acetate & sodium phosphate (CELESTONE) injection
Dose: **[ 12 mg ]** [ 6 mg ] [ 3 mg ]
Route: **[ intramuscular ]** [ intra-articular ] [ intralesional ]
Frequency: **[ Once ]**
Admin Instructions:
Priority: **[ Routine ]**

( ) betamethasone acetate & sodium phosphate (CELESTONE) injection
Dose: **[ 12 mg ]** [ 6 mg ] [ 3 mg ]
Route: **[ intramuscular ]** [ intra-articular ] [ intralesional ]

Frequency: **[ Q12H ]** [ Once ]
For: 2 Doses
Admin Instructions:
Priority: **[ Routine ]**

( ) betamethasone acetate & sodium phosphate (CELESTONE) injection
Dose: **[ 12 mg ]** [ 6 mg ] [ 3 mg ]
Route: **[ intramuscular ]** [ intra-articular ] [ intralesional ]
Frequency: **[ Q24H ]** [ Once ]
For: 2 Doses
Admin Instructions:
Priority: **[ Routine ]**

[X] Rescue Agents (Selection Required)
[X] calcium gluconate injection
Dose: [ 0.5 g ] **[ 1 g ]** [ 2 g ]
Route: **[ intravenous ]**
Frequency: **[ Once PRN ]** [ Once ]
For: 1 Doses
Admin Instructions:
Administer for respirations less than 12 breaths per minute and call MD.
Calcium GLUCONATE 1 gm = 4.65 MEQ

Priority: **[ Routine ]**

[ ] Labs (Selection Required)
[ ] OB magnesium level
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Starting: Today
Order comments: After loading dose (MD to enter repeat order information)

[ ] OB magnesium level
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments: MD to enter repeat order information

[ ] Comprehensive metabolic panel
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Starting: Tomorrow
Order comments:

[ ] Electrolyte panel
Frequency: **[ Conditional ]** [ Once ] [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
For: 1 Occurrences
Order comments: Electrolyte panel after 24 hours if receiving combination of Pitocin and Magnesium Sulfate therapy

[ ] OB Hypertensive Crisis Panel (Selection Required)
[X] Notify (Selection Required)
[X] Notify physician if systolic blood pressure is greater than or equal to 160 mm Hg or if diastolic blood pressure is greater than or equal to 110 mm Hg
Priority: Routine
Frequency: **[ Until Discontinued ]** [ Once ]
Starting: Today, At: N
Order comments:
Phase of Care:

[ ] Initial First-Line Management - Select one (Selection Required)
( ) Initial First-Line Management with Labetalol (Selection Required)
[ ] Initial First-Line Management with Labetalol (Selection Required)
labetalol (TRANDATE) injection
Dose: [ 2.5 mg ] [ 5 mg ] [ 10 mg ] [ 15 mg ] **[ 20 mg ]** [ 40 mg ] [ 80 mg ]
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Doses
Admin Instructions:
Dose #1 of Labetalol
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.
Priority: **[ Routine ]**

Questions:
BP & HR HOLD parameters for this order: **[ BP & HR HOLD Parameters requested ]** [ ONCE or PRN Orders - No Hold Parameters Needed ]

BP & HR HOLD for: [ Systolic BP LESS than 120 mmHg ] **[ Systolic BP LESS than 100 mmHg ]** [ Other Systolic BP ] [ Other MAP ] [ Other Doppler BP (LVAD) ] [ Heart Rate LESS than 60 bpm ] **[ Heart Rate LESS than 50 bpm ]** [ Other Heart Rate ]

Possible Cascading Questions:

If (answer is BP & HR HOLD Parameters requested):
BP & HR HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other Heart Rate):
Hold for Heart Rate LESS than (in bpm):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

And

labetalol (TRANDATE) injection

Dose: [ 2.5 mg ] [ 5 mg ] [ 10 mg ] [ 15 mg ] [ 20 mg ] **[ 40 mg ]** [ 80 mg ]
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Doses
Admin Instructions:
Dose #2 of Labetalol - If BP threshold still exceeded 10 minutes after first dose administered.
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.
Priority: **[ Routine ]**

Questions:

BP & HR HOLD parameters for this order: **[ BP & HR HOLD Parameters requested ]** [ ONCE or PRN Orders - No Hold Parameters Needed ]
BP & HR HOLD for: [ Systolic BP LESS than 120 mmHg ] **[ Systolic BP LESS than 100 mmHg ]** [ Other Systolic BP ] [ Other MAP ] [ Other Doppler BP (LVAD) ] [ Heart Rate LESS than 60 bpm ] **[ Heart Rate LESS than 50 bpm ]** [ Other Heart Rate ]

Possible Cascading Questions:

If (answer is BP & HR HOLD Parameters requested):
BP & HR HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other Heart Rate):
Hold for Heart Rate LESS than (in bpm):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

And

labetalol (TRANDATE) injection

Dose: [ 2.5 mg ] [ 5 mg ] [ 10 mg ] [ 15 mg ] [ 20 mg ] [ 40 mg ] **[ 80 mg ]**
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Doses
Admin Instructions:
Dose #3 of Labetalol - If BP threshold still exceeded 10 minutes after second dose administered.
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.
Priority: **[ Routine ]**

Questions:

BP & HR HOLD parameters for this order: **[ BP & HR HOLD Parameters requested ]** [ ONCE or PRN Orders - No Hold Parameters Needed ]
BP & HR HOLD for: [ Systolic BP LESS than 120 mmHg ] **[ Systolic BP LESS than 100 mmHg ]** [ Other Systolic BP ] [ Other MAP ] [ Other Doppler BP (LVAD) ] [ Heart Rate LESS than 60 bpm ] **[ Heart Rate LESS than 50 bpm ]** [ Other Heart Rate ]

Possible Cascading Questions:

If (answer is BP & HR HOLD Parameters requested):
BP & HR HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other Heart Rate):
Hold for Heart Rate LESS than (in bpm):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

[ ] hydrALAZINE (APRESOLINE) injection

Dose: [ 2.5 mg ] [ 5 mg ] **[ 10 mg ]** [ 20 mg ]
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Doses
Admin Instructions:
Give 10 minutes AFTER last dose (#3) of Labetalol If BP threshold still exceeded.
Give IV Push over 2 minutes
If AFTER Hydralazine administration BP is BELOW threshold, continue to monitor BP closely
Priority: **[ Routine ]**

Questions:

BP HOLD parameters for this order: **[ BP Hold Parameters requested ]** [ ONCE or PRN Orders - No Hold Parameters Needed ]
BP HOLD for: [ Systolic BP LESS than 120 mmHg ] **[ Systolic BP LESS than 100 mmHg ]** [ Other Systolic BP ] [ Other MAP ] [ Other Doppler BP (LVAD) ]

Possible Cascading Questions:

If (answer is BP Hold Parameters requested):
BP HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

( ) Initial First-Line Management with Hydralazine (Selection Required)

hydrALAZINE (APRESOLINE) injection

Dose: [ 2.5 mg ] **[ 5 mg ]** [ 10 mg ] [ 20 mg ]
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Doses
Admin Instructions:
Give IV Push over 2 minutes
Repeat BP measurements in 20 minutes and record results.
Priority: **[ Routine ]**

Questions:

BP HOLD parameters for this order: [ BP Hold Parameters requested ] **[ ONCE or PRN Orders - No Hold Parameters Needed ]**

Possible Cascading Questions:

If (answer is BP Hold Parameters requested):
BP HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

And

hydrALAZINE (APRESOLINE) injection

Dose: [ 2.5 mg ] [ 5 mg ] **[ 10 mg ]** [ 20 mg ]
Route: **[ intravenous ]**

Frequency: Once PRN
For: 1 Doses
Admin Instructions:
Dose #2 of Hydralazine - If BP threshold still exceeded 20 minutes after first dose administered.
Give IV Push over 2 minutes
Repeat BP measurements in 20 minutes and record results.
Priority: **[ Routine ]**

Questions:

BP HOLD parameters for this order: [ BP Hold Parameters requested ] **[ ONCE or PRN Orders - No Hold Parameters Needed ]**

Possible Cascading Questions:

If (answer is BP Hold Parameters requested):
BP HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

And

labetalol (TRANDATE) injection

Dose: [ 2.5 mg ] [ 5 mg ] [ 10 mg ] [ 15 mg ] **[ 20 mg ]** [ 40 mg ] [ 80 mg ]
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Doses
Admin Instructions:
Dose #1 of Labetalol
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.
Priority: **[ Routine ]**

Questions:

BP & HR HOLD parameters for this order: **[ BP & HR HOLD Parameters requested ]** [ ONCE or PRN Orders - No Hold Parameters Needed ]
BP & HR HOLD for: [ Systolic BP LESS than 120 mmHg ] **[ Systolic BP LESS than 100 mmHg ]** [ Other Systolic BP ] [ Other MAP ] [ Other Doppler BP (LVAD) ] [ Heart Rate LESS than 60 bpm ] **[ Heart Rate LESS than 50 bpm ]** [ Other Heart Rate ]

Possible Cascading Questions:

If (answer is BP & HR HOLD Parameters requested):
BP & HR HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other Heart Rate):
Hold for Heart Rate LESS than (in bpm):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

And

labetalol (TRANDATE) injection

Dose: [ 2.5 mg ] [ 5 mg ] [ 10 mg ] [ 15 mg ] [ 20 mg ] **[ 40 mg ]** [ 80 mg ]
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Doses
Admin Instructions:
Dose #2 of Labetalol - If BP threshold still exceeded 10 minutes after first dose administered.
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.
If either BP threshold is still exceeded, obtain emergency consultation from maternal-fetal medicine, internal medicine, anesthesia, or critical care subspecialists. Give additional anti-hypertensive
medication per specific order.
Priority: **[ Routine ]**

Questions:

BP & HR HOLD parameters for this order: **[ BP & HR HOLD Parameters requested ]** [ ONCE or PRN Orders - No Hold Parameters Needed ]

BP & HR HOLD for: [ Systolic BP LESS than 120 mmHg ] **[ Systolic BP LESS than 100 mmHg ]** [ Other Systolic BP ] [ Other MAP ] [ Other Doppler BP (LVAD) ] [ Heart Rate LESS than 60 bpm ] **[ Heart Rate LESS than 50 bpm ]** [ Other Heart Rate ]

Possible Cascading Questions:

If (answer is BP & HR HOLD Parameters requested):
BP & HR HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other Heart Rate):
Hold for Heart Rate LESS than (in bpm):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

( ) Initial First-Line Management with Oral Nifedipine (Selection Required)

NIFEdipine (PROCARDIA) capsule

Dose: **[ 10 mg ]** [ 20 mg ]
Route: **[ oral ]**
Frequency: **[ Once PRN ]** [ Once ]
For: 1 Doses
Admin Instructions:
Dose #1 of Nifedipine
Repeat BP measurements in 20 minutes and record results.
Priority: **[ Routine ]**

Questions:

BP HOLD parameters for this order: [ BP Hold Parameters requested ] [ ONCE or PRN Orders - No Hold Parameters Needed ]

Possible Cascading Questions:

If (answer is BP Hold Parameters requested):
BP HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

And

NIFEdipine (PROCARDIA) capsule

Dose: [ 10 mg ] **[ 20 mg ]**
Route: **[ oral ]**
Frequency: **[ Once PRN ]** [ Once ]
For: 1 Doses
Admin Instructions:
Dose #2 of Nifedipine
Repeat BP measurements in 20 minutes and record results.
If BP is BELOW threshold, continue to monitor BP closely.
Priority: **[ Routine ]**

Questions:

BP HOLD parameters for this order: [ BP Hold Parameters requested ] [ ONCE or PRN Orders - No Hold Parameters Needed ]

Possible Cascading Questions:

If (answer is BP Hold Parameters requested):
BP HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

And

labetalol (TRANDATE) injection

Dose: [ 2.5 mg ] [ 5 mg ] [ 10 mg ] [ 15 mg ] [ 20 mg ] **[ 40 mg ]** [ 80 mg ]
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Doses
Admin Instructions:
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.
Priority: **[ Routine ]**

Questions:

BP & HR HOLD parameters for this order: **[ BP & HR HOLD Parameters requested ]** [ ONCE or PRN Orders - No Hold Parameters Needed ]
BP & HR HOLD for: [ Systolic BP LESS than 120 mmHg ] **[ Systolic BP LESS than 100 mmHg ]** [ Other Systolic BP ] [ Other MAP ] [ Other Doppler BP (LVAD) ] [ Heart Rate LESS than 60 bpm ] **[ Heart Rate LESS than 50 bpm ]** [ Other Heart Rate ]

Possible Cascading Questions:

If (answer is BP & HR HOLD Parameters requested):
BP & HR HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other Heart Rate):
Hold for Heart Rate LESS than (in bpm):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

[ ] Pre-Eclamptic Lab Panel (Selection Required)

[X] CBC with differential
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Comprehensive metabolic panel
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Prothrombin time with INR
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Partial thromboplastin time
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:
Do not draw blood from the arm that has heparin infusion. Do not draw from heparin flushed lines. If there is no other access other than the heparin line, then stop the heparin, flush the line, and aspirate 20 ml of blood to waste prior to drawing a specimen.

[X] Fibrinogen
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Uric acid
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] LDH
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[ ] Urine Protein and Creatinine (Selection Required)

[X] Creatinine level, urine, random
Frequency: **[ Once ]** [ AM Draw ] [ Timed ] [ Add-on ]
Order comments:

[X] Protein, urine, random

Frequency: **[ Once ]** [ AM Draw ] [ Timed ] [ Add-on ]
Order comments:

[ ] Physician Consult (Selection Required)

[ ] Consult Anesthesiology

Referral Info:
To Location/POS:
Number of Visits: 1
Expiration Date: S+365
Priority: **[ Routine ]** [ STAT ]
Order comments:

Questions:

Reason for Consult?

Conditional Questions:

If Class is Normal Or Class is Hospital Performed Or Class is HMWB Hospital Performed Or Class is HMW Hospital Performed Or Class is HMSTC Hospital Performed:

Patient/clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service notified ] [ Consultant not contacted ]

Possible Cascading Questions:

If (answer is Consultant not contacted):
Will you contact the consultant?
If (answer is No):
Best call back number (Personal contact number):
If (answer is Yes):
Best call back number (Personal contact number):
If (answer is Answering service notified):
Additional information:
Best call back number (Personal contact number):

If (Class is not HMWB Hospital Performed) And (Class is not HMW Hospital Performed) And (Class is not HMSTC Hospital Performed):

Patient/Clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service ]

Possible Cascading Questions:

If (answer is Answering service):
Additional information:
Best call back number (Personal contact number):

[ ] Consult Cardiology

Referral Info:
To Location/POS:
Number of Visits: 1
Expiration Date: S+365
Priority: **[ Routine ]** [ STAT ]
Order comments:
Referred to Provider Specialty: Cardiology

Questions:

Reason for Consult?

Conditional Questions:

If Class is Normal Or Class is Hospital Performed Or Class is HMWB Hospital Performed Or Class is HMW Hospital Performed Or Class is HMSTC Hospital Performed:

Patient/clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service notified ] [ Consultant not contacted ]

Possible Cascading Questions:

If (answer is Consultant not contacted):
Will you contact the consultant?
If (answer is No):
Best call back number (Personal contact number):
If (answer is Yes):
Best call back number (Personal contact number):
If (answer is Answering service notified):
Additional information:
Best call back number (Personal contact number):

If (Class is not HMWB Hospital Performed) And (Class is not HMW Hospital Performed) And (Class is not HMSTC Hospital Performed):

Patient/Clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service ]

Possible Cascading Questions:

If (answer is Answering service):

Additional information:

Best call back number (Personal contact number):

[ ] Consult Neurology

Referral Info:

To Location/POS:

Number of Visits: 1

Expiration Date: S+365

Priority: **[ Routine ]** [ STAT ]

Order comments:

Referred to Provider Specialty: Neurology

Questions:

Reason for Consult? [ Carotid stenosis ] [ Ischemic stroke ] [ Seizure ] [ Venous sinus thrombosis ] [ Dissections/intracranial stenosis ] [ Intracranial Hemorrhage (intracerebral) - Routine ] [ Thrombectomy (>24 hours after procedure) ] [ Syncope ] [ Dizziness/Vertigo ] [ Intractable Headaches ] [ Encephalopathy ] [ Demyelinating Disease ] [ Inflammatory neuropathy ] [ Other Reasons ]

Possible Cascading Questions:

If (answer is Other Reasons):

Other reasons:

Conditional Questions:

If Class is Normal Or Class is Hospital Performed Or Class is HMWB Hospital Performed Or Class is HMW Hospital Performed Or Class is HMSTC Hospital Performed:

Patient/clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service notified ] [ Consultant not contacted ]

Possible Cascading Questions:

If (answer is Consultant not contacted):

Will you contact the consultant?

If (answer is No):

Best call back number (Personal contact number):

If (answer is Yes):

Best call back number (Personal contact number):

If (answer is Answering service notified):

Additional information:

Best call back number (Personal contact number):

If (Class is not HMWB Hospital Performed) And (Class is not HMW Hospital Performed) And (Class is not HMSTC Hospital Performed):

Patient/Clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service ]

Possible Cascading Questions:

If (answer is Answering service):

Additional information:

Best call back number (Personal contact number):

[ ] Consult Maternal and Fetal Medicine

Referral Info:

To Location/POS:

Number of Visits: 1

Expiration Date: S+365

Priority: **[ Routine ]** [ STAT ]

Order comments:

Referred to Provider Specialty: Maternal and Fetal Medicine

Questions:

Reason for Consult?

Conditional Questions:

If Class is Normal Or Class is Hospital Performed Or Class is HMWB Hospital Performed Or Class is HMW Hospital Performed Or Class is HMSTC Hospital Performed:

Patient/clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service notified ] [ Consultant not contacted ]

Possible Cascading Questions:

If (answer is Consultant not contacted):

Will you contact the consultant?
If (answer is No):
Best call back number (Personal contact number):
If (answer is Yes):
Best call back number (Personal contact number):
If (answer is Answering service notified):
Additional information:
Best call back number (Personal contact number):

If (Class is not HMWB Hospital Performed) And (Class is not HMW Hospital Performed) And (Class is not HMSTC Hospital Performed):

Patient/Clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service ]

Possible Cascading Questions:

If (answer is Answering service):
Additional information:
Best call back number (Personal contact number):

[ ] Consult Neonatology

Referral Info:
To Location/POS:
Number of Visits: 1
Expiration Date: S+365
Priority: **[ Routine ]** [ STAT ]
Order comments:
Referred to Provider Specialty: Neonatology

Questions:

Reason for Consult?

Conditional Questions:

If Class is Normal Or Class is Hospital Performed Or Class is HMWB Hospital Performed Or Class is HMW Hospital Performed Or Class is HMSTC Hospital Performed:

Patient/clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service notified ] [ Consultant not contacted ]

Possible Cascading Questions:

If (answer is Consultant not contacted):
Will you contact the consultant?
If (answer is No):
Best call back number (Personal contact number):
If (answer is Yes):
Best call back number (Personal contact number):
If (answer is Answering service notified):
Additional information:
Best call back number (Personal contact number):

If (Class is not HMWB Hospital Performed) And (Class is not HMW Hospital Performed) And (Class is not HMSTC Hospital Performed):

Patient/Clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service ]

Possible Cascading Questions:

If (answer is Answering service):
Additional information:
Best call back number (Personal contact number):

[ ] Consult Obstetrics and Gynecology

Referral Info:
To Location/POS:
Number of Visits: 1
Expiration Date: S+365
Priority: **[ Routine ]** [ STAT ]
Order comments:
Referred to Provider Specialty: Obstetrics and Gynecology

Questions:

Reason for Consult?

Conditional Questions:

If Class is Normal Or Class is Hospital Performed Or Class is HMWB Hospital Performed Or Class is HMW Hospital Performed Or Class is HMSTC Hospital Performed:

Patient/clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service notified ] [

Consultant not contacted ]

Possible Cascading Questions:

If (answer is Consultant not contacted):
Will you contact the consultant?
If (answer is No):
Best call back number (Personal contact number):
If (answer is Yes):
Best call back number (Personal contact number):
If (answer is Answering service notified):
Additional information:
Best call back number (Personal contact number):

If (Class is not HMWB Hospital Performed) And (Class is not HMW Hospital Performed) And (Class is not HMSTC Hospital Performed):

Patient/Clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service ]

Possible Cascading Questions:

If (answer is Answering service):
Additional information:
Best call back number (Personal contact number):

## Nursing

### Vital Signs

#### [X] Vital signs - T/P/R/BP (per unit protocol)

Priority: **[ Routine ]** [ STAT ]
Frequency: [ Q1H ] [ Q2H ] [ Q4H ] **[ Per Unit Protocol ]**
Order comments: Per Guidelines of Care
Scheduling Instructions:

### Activity

#### [ ] Strict bed rest

Priority: **[ Routine ]**
Frequency: **[ Until Discontinued ]** [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments:
Scheduling Instructions:

#### [X] Bed rest with bathroom privileges

Priority: **[ Routine ]**
Frequency: **[ Until Discontinued ]** [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments:
Scheduling Instructions:

Questions:

Bathroom Privileges: **[ with bathroom privileges ]** [ with bedside commode ]

#### [ ] May use birthing ball

Priority: **[ Routine ]**
Frequency: [ Once ] **[ Until Discontinued ]**
Starting: Today, At: N
Order comments:
Scheduling Instructions:

#### [ ] Bed rest with bathroom privileges for BM

Priority: **[ Routine ]**
Frequency: **[ Until Discontinued ]** [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments: For BM
Scheduling Instructions:

Questions:

Bathroom Privileges: **[ with bathroom privileges ]** [ with bedside commode ]

#### [ ] Activity as tolerated

Priority: **[ Routine ]**
Frequency: **[ Until Discontinued ]** [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments:

Scheduling Instructions:

Questions:

Specify: **[ Activity as tolerated ]** [ Up ad lib ] [ Out of bed ] [ Up in chair ] [ Up with assistance ] [ Other activity (specify) ]

Possible Cascading Questions:

If (answer is Up in chair):
Additional modifier:
If (answer is Other activity (specify)):
Other:

[ ] May use Whirlpool tub if membranes intact

Priority: **[ Routine ]**
Frequency: [ Once ] **[ Until Discontinued ]**
Starting: Today, At: N
Order comments:
Scheduling Instructions:

Nursing Care

[X] Apply external fetal monitor (Selection Required)

[X] Monitor fetal heart tones continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]** [ Once ] [ Q3H ] [ Q4H ] [ Q Shift ] [ Daily ]
Order comments:
Scheduling Instructions:

Questions:

Type: **[ Continuous ]** [ Intermittent Monitoring ] [ High risk ] [ Low risk ]

[ ] Monitor fetal heart tones intermittent

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]** [ Once ] [ Q3H ] [ Q4H ] [ Q Shift ] [ Daily ]
Order comments:
Scheduling Instructions:

Questions:

Type: **[ Intermittent ]** [ Continuous ] [ Intermittent Monitoring ] [ High risk ] [ Low risk ]

[ ] Fetal nonstress test

Priority: **[ Routine ]** [ STAT ] [ Timed ]
Frequency: **[ Once ]** [ Daily ] [ PRN ] [ BID ] [ TID ] [ 4x Daily ]
Order comments:
Scheduling Instructions:

[X] Tocometry

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Until Discontinued ]** [ Once ] [ Q3H ] [ Q4H ] [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments:
Scheduling Instructions:

Questions:

Type: **[ Continuous ]** [ Intermittent ]

[ ] Apply internal fetal monitor (FSE) (Selection Required)

[X] Fetal scalp monitor

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]** [ Once ] [ Q3H ] [ Q4H ] [ Q Shift ] [ Daily ]
Process Instructions: DO NOT place Fetal Scalp Electrode if patient is HIV or HSV positive.
Order comments:
Scheduling Instructions:

Questions:

Indication: May place Fetal Scalp Electrode if unable to adequately monitor fetal heart tones and membranes are ruptured.
May place if GBS positive: **[ Yes ]** [ No ]

[X] Sterile vaginal exam

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Until Discontinued ]** [ Once ] [ Q3H ] [ Q4H ] [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments: Perform sterile vaginal exam to monitor progression or if clinically indicated
Scheduling Instructions:

[ ] For urinary retention: Assist patient to void on bedpan in upright position prior to straight cath x 1 followed by placement of indwelling urinary catheter if necessary

Priority: **[ Routine ]**
Frequency: [ Once ] **[ Until Discontinued ]**
Starting: Today, At: N
Order comments:
Scheduling Instructions:

[ ] Straight cath

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Conditional ]** [ Once ] [ Q4H ] [ Q Shift ] [ Daily ]
For: 1 Occurrences
Order comments: If patient unable to void on bedpan, preferably in upright position, straight cath x 1. If patient unable to void after 1st straight cath, insert indwelling urinary catheter.
Scheduling Instructions:

[X] Insert and maintain Foley (Selection Required)

[X] Insert Foley catheter

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Conditional ]** [ Once ] [ Q4H ] [ Q Shift ] [ Daily ]
For: 1 Occurrences
Order comments: If regional block and patient unable to void insert indwelling urinary catheter.
Scheduling Instructions:

Questions:

Type: [ 2 Way ] [ 3 Way ] [ Coude ] [ Temperature Sensing ]
Size: [ 14 French ] [ 16 French ] [ 18 French ]
Urinometer needed: [ Yes ] [ No ]
Indication: [ Comfort ] [ Hemodynamic Monitoring ] [ Obstruction ] [ Retention ] [ Urologic ] [ Surgery ]

[X] Foley Catheter Care

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Conditional ]** [ Until Discontinued ] [ Daily ]
For: 1 Occurrences
Order comments:
Scheduling Instructions:

Questions:

Orders: [ to gravity ] [ to leg bag ] [ flush ] [ flush until clear ] [ Site care Qshift & PRN ] [ Maintain ] [ Irrigate urinary catheter PRN ] [ Do not manipulate ]

[ ] Patient may have epidural

Priority: Routine
Frequency: **[ Once ]**
Order comments: Notify Anesthesia immediately upon patient's request and begin pre-epidural hydration
Scheduling Instructions:

[ ] Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments:

Questions:

Side: **[ Bilateral ]** [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

[ ] Place antiembolic stockings

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Until Discontinued ]** [ Once ] [ Q4H ] [ Q Shift ] [ Daily ]
Starting: Today, At: N
Order comments:

Questions:

Side: **[ Bilateral ]** [ Left ] [ Right ]
Hose length: [ Thigh-high ] **[ Knee-high ]**

## Notify

### [X] Notify Physician for vitals:

Priority: Routine
Frequency: **[ Until Discontinued ]** [ Once ]
Starting: Today, At: N
Order comments:

#### Questions:

Temperature greater than: 100.3
Temperature less than:
If HM ORD POST LVO AND POST ALTEPLASE NOT ACTIVE is satisfied:
Systolic BP greater than: 160
If HM ORD POST LVO AND POST ALTEPLASE NOT ACTIVE is satisfied:
Systolic BP less than: 90
If HM ORD POST LVO AND POST ALTEPLASE NOT ACTIVE is satisfied:
Diastolic BP greater than: 110
If HM ORD POST LVO AND POST ALTEPLASE NOT ACTIVE is satisfied:
Diastolic BP less than: 50
If HM ORD POST LVO AND POST ALTEPLASE NOT ACTIVE is satisfied:
MAP less than:
Heart rate greater than (BPM):
Heart rate less than (BPM):
Respiratory rate greater than: 24
Respiratory rate less than: 10
SpO2 less than:

### [X] Notify Anesthesiologist immediately if patient requests an epidural and begin pre-epidural hydration

Priority: Routine
Frequency: **[ Until Discontinued ]** [ Once ]
Starting: Today, At: N
Order comments:
Phase of Care:

### [X] Notify Nursery and Neonatologist to attend delivery if indicated

Priority: Routine
Frequency: **[ Until Discontinued ]** [ Once ]
Starting: Today, At: N
Order comments:
Phase of Care:

### [ ] Notify (General)

Priority: Routine
Frequency: **[ Until Discontinued ]** [ Once ]
Starting: Today, At: N
Order comments:
Phase of Care:

## Bowel Care

### [ ] Tap water enema

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Once ]** [ Q4H ] [ Q Shift ] [ Daily ]
Order comments: On Admission
Scheduling Instructions:

### [ ] mineral oil enema

Dose: **[ 1 enema ]**
Route: **[ rectal ]**
Frequency: [ Once ] **[ Once PRN ]**
For: 1 Doses
Admin Instructions: Once on admission
Priority: **[ Routine ]**

## Consent

### [X] Complete Consent Form

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Once ]** [ Q4H ] [ Q Shift ] [ Daily ]
Order comments:
Scheduling Instructions:

#### Questions:

Consent For: Delivery

Procedure: Vaginal delivery of fetus and placenta with possible cesarean section, possible episiotomy, and possible use of vacuum/forceps.
Diagnosis/Condition:
Physician:
Risks, benefits, and alternatives (as outlined by the Texas Medical Disclosure Panel, as appears on Houston Methodist Medical/Surgical Consent forms) were discussed with patient/surrogate? [ Yes ] [ No ] [ Unknown ]

## Diet

### [ ] NPO

Process Instructions: An NPO order without explicit exceptions means nothing can be given orally to the patient.
Frequency: [ Effective Midnight ] **[ Effective Now ]** [ Effective 0500 (Breakfast) ] [ Effective 1000 (Lunch) ] [ Effective 1400 (Dinner) ] [ Effective _____ ]
Starting: Today, At: N
Order comments:

#### Questions:

NPO: [ Except meds ] [ Except Ice chips ] [ Except Sips with meds ] [ Except Sips of clear liquids ]
Pre-Operative fasting options:

#### Possible Cascading Questions:

If (answer is Other):
Specify:

### [X] NPO with ice chips

Process Instructions: An NPO order without explicit exceptions means nothing can be given orally to the patient.
Frequency: [ Effective Midnight ] **[ Effective Now ]** [ Effective 0500 (Breakfast) ] [ Effective 1000 (Lunch) ] [ Effective 1400 (Dinner) ] [ Effective _____ ]
Starting: Today, At: N
Order comments: 1/2 cup per hour

#### Questions:

NPO: [ Except meds ] **[ Except Ice chips ]** [ Except Sips with meds ] [ Except Sips of clear liquids ]
Pre-Operative fasting options:

#### Possible Cascading Questions:

If (answer is Other):
Specify:

### [ ] Diet - Clear liquids

Frequency: **[ Effective Now ]** [ Effective 0500 (Breakfast) ] [ Effective 1000 (Lunch) ] [ Effective 1400 (Dinner) ] [ Effective Midnight ] [ Effective _____ ] [ Effective tomorrow ]
Starting: Today, At: N
Order comments:

#### Questions:

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 ] [ IDDSI/Dysphagia ] [ Bariatric ] [ Other Diabetic/Cal ] [ Other Protein ]

#### Possible Cascading Questions:

If (answer is IDDSI/Dysphagia):
IDDSI Solid Consistency:
If (answer is Other Diabetic/Cal):
Diabetic/Calorie:
If (answer is Other Protein):
Protein:
If (answer is Bariatric):
Bariatric:

Advance Diet as Tolerated? [ Yes ] [ No ]

#### Possible Cascading Questions:

If (answer is Yes):
Target Diet:
Advance target diet criteria:

IDDSI Liquid Consistency: [ Level 1 Slightly Thick ] [ Level 2 Mildly Thick ] [ Level 3 Moderately Thick ] [ Level 4 Extremely Thick ]
Fluid Restriction: [ Fluid Restriction 500 ml ] [ Fluid Restriction 750 ml ] [ Fluid Restriction 1000 ml ] [ Fluid Restriction 1200 ml ] [ Fluid Restriction 1500 ml ] [ No Fluids ]
If HM ORD NOT ACTIVE LUNG TRANSPLANT EPISDOE is satisfied:

Foods to Avoid:
Cultural/Special: [ Kosher ] [ Middle Eastern ] [ Vegetarian ] [ Gluten Free ] [ Vegan ]
Other Options: [ Finger Foods ] [ Safety Tray ]

## IV Fluids

### IV Fluids

#### [X] lactated ringers (LR) or sodium chloride 0.9% (NS) bolus (Selection Required)

Due to IV shortage, LR or NS will be administered based on availability

##### lactated ringers bolus

Dose: [ 250 mL ] [ 500 mL ] **[ 1,000 mL ]**
Route: **[ intravenous ]**
Frequency: **[ Once PRN ]** [ Once ]
For: 1 Doses
Admin Duration: [ 15 Minutes ] **[ 30 Minutes ]** [ 60 Minutes ]
Admin Instructions: Notify Anesthesiologist immediately if patient requests Epidural and begin pre-epidural hydration. Due to IV shortage, LR or NS will be administered based on availability
Priority: **[ Routine ]**

Or

##### sodium chloride 0.9 % bolus

Dose: [ 500 mL ] **[ 1,000 mL ]**
Route: **[ intravenous ]**
Frequency: **[ Once PRN ]** [ Once ]
For: 1 Doses
Admin Duration: 30 Minutes
Admin Instructions: Notify Anesthesiologist immediately if patient requests Epidural and begin pre-epidural hydration. Due to IV shortage, LR or NS will be administered based on availability
Priority: **[ Routine ]**

#### [X] lactated ringers (LR) or sodium chloride 0.9% (NS) infusion (Selection Required)

Due to IV shortage, LR or NS will be administered based on availability

##### lactated ringer's infusion

Dose: [ 50 mL/hr ] [ 75 mL/hr ] [ 100 mL/hr ] **[ 125 mL/hr ]**
Route: **[ intravenous ]**
Frequency: **[ Once ]** [ Continuous ]
Admin Instructions: Due to IV shortage, LR or NS will be administered based on availability
Priority: **[ Routine ]**

Or

##### sodium chloride 0.9 % infusion

Dose: 125 mL/hr
Route: **[ intravenous ]**
Frequency: **[ Once ]** [ Continuous ]
Admin Instructions: Due to IV shortage, LR or NS will be administered based on availability
Priority: **[ Routine ]**

#### [ ] dextrose 5 % and lactated ringers infusion

Dose: **[ 125 mL/hr ]** [ 250 mL/hr ]
Route: **[ intravenous ]**
Frequency: **[ Continuous ]**
For: 24 Hours
Admin Instructions:
Priority: **[ Routine ]**

### Peripheral IV Access

#### [X] Initiate and maintain IV (Selection Required)

##### [X] Insert peripheral IV

Priority: **[ Routine ]**
Frequency: **[ Once ]**
Order comments:
Scheduling Instructions:

##### [X] sodium chloride 0.9 % flush

Dose: [ 2 mL ] [ 3 mL ] [ 5 mL ] **[ 10 mL ]**
Route: **[ intravenous ]** [ intra-catheter ]
Frequency: **[ Q12H SCH ]** [ Q8H ] [ PRN ]

Admin Instructions: if IV is saline locked
Priority: **[ Routine ]**

[X] sodium chloride 0.9 % flush
Dose: [ 2 mL ] [ 3 mL ] [ 5 mL ] **[ 10 mL ]**
Route: **[ intravenous ]** [ intra-catheter ]
Frequency: [ Q8H ] **[ PRN ]**
Admin Instructions:
Priority: **[ Routine ]**

Medications

Nitrous Oxide Orders Only Appears If: **SB IP ORDERSET HMWB HMCY ONLY**

[ ] Nitrous Oxide Administration Orders (Selection Required)

[X] Activity

[X] Fall precautions - while using nitrous oxide
Priority: **[ Routine ]** [ STAT ]
Order comments:

Questions:
Increased observation level needed: [ Yes ] [ No ]

Possible Cascading Questions:
If (answer is Yes):
Level:
For:
Time:

[X] Consent (Selection Required)

[X] Complete Consent Form
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Once ]** [ Q4H ] [ Q Shift ] [ Daily ]
Order comments:
Scheduling Instructions:

Questions:
Consent For: Use of Nitrous Oxide
Procedure: Use of Nitrous Oxide for pain control
Diagnosis/Condition:
Physician:
Risks, benefits, and alternatives (as outlined by the Texas Medical Disclosure Panel, as appears on Houston Methodist Medical/Surgical Consent forms) were discussed with patient/surrogate? [ Yes ] [ No ] [ Unknown ]

[X] Vital Signs (Selection Required) Only Appears If: **SB IP ORDERSET HMWB HMCY ONLY**

[ ] Continuous Fetal monitoring
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Once ]** [ Q3H ] [ Q4H ] [ Q Shift ] [ Daily ]
Order comments:
Scheduling Instructions:

[X] Vital Signs - Nitrous Oxide use
Priority: **[ Routine ]** [ STAT ]
Frequency: [ Q1H ] [ Q2H ] [ Q4H ] **[ Per Unit Protocol ]**
For: Until specified
Order comments:
Nitrous Oxide Use - Baseline Vital signs within One Hour prior to administration,
Vital signs 15 minutes after start time,
Vital signs hourly throughout duration of use,
Pain scale documented every 15 minutes during Nitrous Oxide use
Scheduling Instructions:

[X] Continuous Oxygen saturation monitoring
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Once ]** [ Q3H ] [ Q4H ] [ Q Shift ] [ Daily ]
Order comments:
Scheduling Instructions:

[X] Patient Education (Selection Required)

[X] RN to provide patient education prior to the initiation of Nitrous Oxide.
Priority: **[ Routine ]**
Frequency: [ Once ] **[ Until Discontinued ]**

Starting: Today, At: N
Order comments:
Scheduling Instructions:

[X] Nitrous Oxide (Selection Required)

[X] nitrous oxide gas
Route: **[ inhalation ]**
Frequency: **[ Continuous PRN ]**
Admin Instructions:
Priority: **[ Routine ]**

Antibiotics

Does your patient have a penicillin allergy?

( ) No (Selection Required)

[X] Antibiotics: if GBS+ or Unknown (Selection Required)

(X) penicillin G IVPB Loading and Maintenance Dose - Prophylaxis Regimen for GBS (Selection Required)

Loading Dose - penicillin G (POTASSIUM) IV
Dose: 5 Million Units
Route: **[ intravenous ]**
Frequency: Once
Admin Duration: **[ 30 Minutes ]**
Admin Instructions: If GBS positive
Priority: **[ STAT ]** [ Routine ]

Questions:
Indication: **[ Medical Prophylaxis ]** [ Surgical Prophylaxis ] [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]

Possible Cascading Questions:
If (answer is Other):
Specify:

Followed by

Maintenance Dose - penicillin G (POTASSIUM) IV
Dose: 2.5 Million Units
Route: **[ intravenous ]**
Frequency: Q4H
Starting: 4 Hours after signing
Admin Duration: **[ 30 Minutes ]**
Admin Instructions: If GBS positive
Priority: **[ STAT ]** [ Routine ]

Questions:
Indication: **[ Medical Prophylaxis ]** [ Surgical Prophylaxis ] [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]

Possible Cascading Questions:
If (answer is Other):
Specify:

( ) ampicillin IVPB Loading and Maintenance Dose - Alternative Regimen for GBS (Selection Required)

Loading Dose - ampicillin IV
Dose: 2 g
Route: **[ intravenous ]**
Frequency: Once
Admin Instructions: If GBS positive
Priority: [ Routine ] **[ STAT ]**

Questions:
Indication: **[ Medical Prophylaxis ]** [ Surgical Prophylaxis ] [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Specify:

Followed by

Maintenance Dose - ampicillin IV

Dose: 1 g
Route: **[ intravenous ]**
Frequency: Q4H
Starting: 4 Hours after signing
Admin Instructions: If GBS positive
Priority: [ Routine ] **[ STAT ]**

Questions:

Indication: **[ Medical Prophylaxis ]** [ Surgical Prophylaxis ] [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Specify:

[X] Prophylaxis Regimen for C-section (Selection Required)

[X] Patients LESS than or equal to 120 kg (Selection Required) Only Appears If: **SB WEIGHT </= 120 KG**

[X] ceFAZolin (ANCEF) IV - Give within 60 minutes prior to C-Section

Dose: 2 g
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Days
Admin Instructions: Give within 60 minutes prior to C-Section
Priority: [ Routine ] **[ STAT ]**

Questions:

Indication: [ Medical Prophylaxis ] **[ Surgical Prophylaxis ]** [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]
Surgical Prophylaxis: [ Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration ]

Possible Cascading Questions:

If (answer is Other):
Specify:
If (answer is Bloodstream):
Recommendation:
If (answer is Bone/Joint):
Recommendation:
If (answer is CNS):
Recommendation:
If (answer is ENT/Dental Infection):
Recommendation:
If (answer is Febrile Neutropenia):
Recommendation:
If (answer is Intra-abdominal):
Recommendation:
If (answer is Respiratory Tract):
Recommendation:
If (answer is Sepsis of Unknown Source):
Recommendation:
If (answer is Skin and Soft Tissue Infections):
Recommendation:
If (answer is Uro/Genital):
Recommendation:
If (answer is Cardiovascular):
Recommendation:
If (answer is TB/Mycobacterial):
Recommendation:
If (answer is Nocardia):
Recommendation:
If (answer is Medical Prophylaxis):
Medical Prophylaxis:
If (answer is Surgical Prophylaxis):
Surgical Prophylaxis:

[X] azithromycin (ZITHROMAX) IV - Give within 60 minutes prior to C-Section

Dose: [ 250 mg ] **[ 500 mg ]**
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Days
Admin Instructions: Give within 60 minutes prior to C-Section
Priority: **[ STAT ]** [ Routine ]

Questions:

Indication: [ Medical Prophylaxis ] **[ Surgical Prophylaxis ]** [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]
Surgical Prophylaxis: [ Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration ]

Possible Cascading Questions:

If (answer is Other):
Specify:
If (answer is Bone/Joint):
Recommendation:
If (answer is CNS):
Recommendation:
If (answer is ENT/Dental Infection):
Recommendation:
If (answer is Respiratory Tract):
Recommendation:
If (answer is Sepsis of Unknown Source):
Recommendation:
If (answer is Skin and Soft Tissue Infections):
Recommendation:
If (answer is Cardiovascular):
Recommendation:
If (answer is TB/Mycobacterial):
Recommendation:
If (answer is Nocardia):
Recommendation:
If (answer is Medical Prophylaxis):
Medical Prophylaxis:
If (answer is Surgical Prophylaxis):
Surgical Prophylaxis:

[X] Patients GREATER than 120 kg (Selection Required) Only Appears If: **SB WEIGHT > 120 KG**

[X] ceFAZolin (ANCEF) IV - Give within 60 minutes prior to C-Section

Dose: 3 g
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Days
Admin Instructions: Give within 60 minutes prior to C-Section
Priority: [ Routine ] **[ STAT ]**

Questions:

Indication: [ Medical Prophylaxis ] **[ Surgical Prophylaxis ]** [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]
Surgical Prophylaxis: [ Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration ]

Possible Cascading Questions:

If (answer is Other):
Specify:
If (answer is Bloodstream):
Recommendation:
If (answer is Bone/Joint):
Recommendation:
If (answer is CNS):
Recommendation:
If (answer is ENT/Dental Infection):
Recommendation:
If (answer is Febrile Neutropenia):
Recommendation:
If (answer is Intra-abdominal):
Recommendation:
If (answer is Respiratory Tract):
Recommendation:

If (answer is Sepsis of Unknown Source):
Recommendation:
If (answer is Skin and Soft Tissue Infections):
Recommendation:
If (answer is Uro/Genital):
Recommendation:
If (answer is Cardiovascular):
Recommendation:
If (answer is TB/Mycobacterial):
Recommendation:
If (answer is Nocardia):
Recommendation:
If (answer is Medical Prophylaxis):
Medical Prophylaxis:
If (answer is Surgical Prophylaxis):
Surgical Prophylaxis:

[X] azithromycin (ZITHROMAX) IV - Give within 60 minutes prior to C-Section

Dose: [ 250 mg ] **[ 500 mg ]**
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Days
Admin Instructions: Give within 60 minutes prior to C-Section
Priority: **[ STAT ]** [ Routine ]

Questions:

Indication: [ Medical Prophylaxis ] **[ Surgical Prophylaxis ]** [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]
Surgical Prophylaxis: [ Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration ]

Possible Cascading Questions:

If (answer is Other):
Specify:
If (answer is Bone/Joint):
Recommendation:
If (answer is CNS):
Recommendation:
If (answer is ENT/Dental Infection):
Recommendation:
If (answer is Respiratory Tract):
Recommendation:
If (answer is Sepsis of Unknown Source):
Recommendation:
If (answer is Skin and Soft Tissue Infections):
Recommendation:
If (answer is Cardiovascular):
Recommendation:
If (answer is TB/Mycobacterial):
Recommendation:
If (answer is Nocardia):
Recommendation:
If (answer is Medical Prophylaxis):
Medical Prophylaxis:
If (answer is Surgical Prophylaxis):
Surgical Prophylaxis:

( ) Yes (Selection Required)

[X] Penicillin Allergic and GBS + (Selection Required)

( ) ceFAZolin (ANCEF) IV Loading and Maintenance Doses - if GBS Positive (Selection Required)

Recommended for patients NOT high risk for anaphylaxis

Loading Dose - cefazolin (ANCEF) IV

Dose: 2 g
Route: **[ intravenous ]**
Frequency: Once
Admin Instructions: If GBS positive
Priority: [ Routine ] **[ STAT ]**

Questions:

Indication: **[ Medical Prophylaxis ]** [ Surgical Prophylaxis ] [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile

Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]
Medical Prophylaxis: [ The maximum duration of therapy that can be entered at this time is 56 days. Order can be renewed if required at that time. ]

Possible Cascading Questions:

If (answer is Other):
Specify:
If (answer is Bloodstream):
Recommendation:
If (answer is Bone/Joint):
Recommendation:
If (answer is CNS):
Recommendation:
If (answer is ENT/Dental Infection):
Recommendation:
If (answer is Febrile Neutropenia):
Recommendation:
If (answer is Intra-abdominal):
Recommendation:
If (answer is Respiratory Tract):
Recommendation:
If (answer is Sepsis of Unknown Source):
Recommendation:
If (answer is Skin and Soft Tissue Infections):
Recommendation:
If (answer is Uro/Genital):
Recommendation:
If (answer is Cardiovascular):
Recommendation:
If (answer is TB/Mycobacterial):
Recommendation:
If (answer is Nocardia):
Recommendation:
If (answer is Medical Prophylaxis):
Medical Prophylaxis:
If (answer is Surgical Prophylaxis):
Surgical Prophylaxis:

Followed by

Maintenance Dose - cefazolin (ANCEF) IV

Dose: 1 g
Route: **[ intravenous ]**
Frequency: Q8H
Admin Instructions:
If GBS positive.

Through delivery then discontinue.
Priority: [ Routine ] **[ STAT ]**

Questions:

If 18 years and older:
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values. [ Contact provider before making renal dose adjustments ]

Possible Cascading Questions:

If (answer is Contact provider before making renal dose adjustments):
Contact Number:

Indication: **[ Medical Prophylaxis ]** [ Surgical Prophylaxis ] [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]
Medical Prophylaxis: [ The maximum duration of therapy that can be entered at this time is 56 days. Order can be renewed if required at that time. ]

Possible Cascading Questions:

If (answer is Other):
Specify:
If (answer is Bloodstream):
Recommendation:
If (answer is Bone/Joint):
Recommendation:
If (answer is CNS):
Recommendation:

If (answer is ENT/Dental Infection):
Recommendation:
If (answer is Febrile Neutropenia):
Recommendation:
If (answer is Intra-abdominal):
Recommendation:
If (answer is Respiratory Tract):
Recommendation:
If (answer is Sepsis of Unknown Source):
Recommendation:
If (answer is Skin and Soft Tissue Infections):
Recommendation:
If (answer is Uro/Genital):
Recommendation:
If (answer is Cardiovascular):
Recommendation:
If (answer is TB/Mycobacterial):
Recommendation:
If (answer is Nocardia):
Recommendation:
If (answer is Medical Prophylaxis):
Medical Prophylaxis:
If (answer is Surgical Prophylaxis):
Surgical Prophylaxis:

( ) clindamycin (CLEOCIN) IV Loading and Maintenance Doses - if GBS Positive (Selection Required)

Recommended ONLY for patients with high risk for penicillin anaphylaxis that are culture isolate sensitive to Clindamycin.

Loading Dose - clindamycin (CLEOCIN) IV

Dose: 900 mg
Route: **[ intravenous ]**
Frequency: Once
Admin Duration: **[ 30 Minutes ]**
Admin Instructions: If GBS positive
Priority: [ Routine ] **[ STAT ]** [ Timed ]

Questions:

Indication: **[ Medical Prophylaxis ]** [ Surgical Prophylaxis ] [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Specify:

Followed by

Maintenance Dose - clindamycin (CLEOCIN) IV

Dose: 900 mg
Route: **[ intravenous ]**
Frequency: Q8H
Admin Duration: **[ 30 Minutes ]**
Admin Instructions:
If GBS positive.

Through delivery then discontinue.
Priority: [ Routine ] **[ STAT ]** [ Timed ]

Questions:

Indication: **[ Medical Prophylaxis ]** [ Surgical Prophylaxis ] [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Specify:

( ) vancomycin (VANCOCIN) IVPB - if GBS Positive (Selection Required)

Adjust doses for renal function if CrCl LESS THAN 60 mL/min

[X] vancomycin (VANCOCIN) IV (Selection Required)

[X] vancomycin (VANCOCIN) IV

Dose:
Route: **[ intravenous ]**
Frequency: **[ Once ]**
Admin Duration:
Admin Instructions: Loading Dose
Priority: **[ STAT ]** [ Routine ]

Questions:

If 18 years and older:
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values. [ Contact provider before making renal dose adjustments ]

Possible Cascading Questions:

If (answer is Contact provider before making renal dose adjustments):
Contact Number:

Indication: [ Medical Prophylaxis ] [ Surgical Prophylaxis ] [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Specify:
If (answer is Bloodstream):
Recommendation:
If (answer is Bone/Joint):
Recommendation:
If (answer is CNS):
Recommendation:
If (answer is ENT/Dental Infection):
Recommendation:
If (answer is Febrile Neutropenia):
Recommendation:
If (answer is Intra-abdominal):
Recommendation:
If (answer is Respiratory Tract):
Recommendation:
If (answer is Sepsis of Unknown Source):
Recommendation:
If (answer is Skin and Soft Tissue Infections):
Recommendation:
If (answer is Uro/Genital):
Recommendation:
If (answer is Cardiovascular):
Recommendation:
If (answer is TB/Mycobacterial):
Recommendation:
If (answer is Nocardia):
Recommendation:
If (answer is Medical Prophylaxis):
Medical Prophylaxis:
If (answer is Surgical Prophylaxis):
Surgical Prophylaxis:

[X] Pharmacy consult to manage vancomycin

Priority: **[ Routine ]** [ STAT ]
Order comments:
Process Instructions: All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

Questions:

Indication: [ Medical Prophylaxis ] [ Surgical Prophylaxis ] [ Bloodstream ] [ Bone/Joint ] [ CNS ] [ ENT/Dental Infection ] [ Febrile Neutropenia ] [ Intra-abdominal ] [ Respiratory Tract ] [ Ophthalmic ] [ Sepsis of Unknown Source ] [ Skin and Soft Tissue Infections ] [ Uro/Genital ] [ Cardiovascular ] [ TB/Mycobacterial ] [ Nocardia ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Specify:
If (answer is Bloodstream):
Recommendation:
If (answer is Bone/Joint):
Recommendation:
If (answer is CNS):

Recommendation:
If (answer is ENT/Dental Infection):
Recommendation:
If (answer is Febrile Neutropenia):
Recommendation:
If (answer is Intra-abdominal):
Recommendation:
If (answer is Respiratory Tract):
Recommendation:
If (answer is Sepsis of Unknown Source):
Recommendation:
If (answer is Skin and Soft Tissue Infections):
Recommendation:
If (answer is Uro/Genital):
Recommendation:
If (answer is Cardiovascular):
Recommendation:
If (answer is TB/Mycobacterial):
Recommendation:
If (answer is Nocardia):
Recommendation:
If (answer is Medical Prophylaxis):
Medical Prophylaxis:
If (answer is Surgical Prophylaxis):
Surgical Prophylaxis:

Anticipated Duration of Vancomycin Therapy (Days):

[X] Prophylaxis Regimen for C-section (Selection Required)

azithromycin (ZITHROMAX)

Dose: [ 250 mg ] **[ 500 mg ]**
Route: **[ intravenous ]**
Frequency: Once
Admin Instructions: Nurse to send medication(s) to operating room - To be administered by Anesthesiologist.To be given 1 hour prior to skin incision.
Priority: **[ STAT ]** [ Routine ]

Questions:

If 18 years and older:
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied: [ Call me before conversion to PO ]

Possible Cascading Questions:

If (answer is Call me before conversion to PO):
Contact Number:

Surgical Prophylaxis: [ Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration ]

And

clindamycin (CLEOCIN) IV

Dose: 900 mg
Route: **[ intravenous ]**
Frequency: Once
Admin Duration: **[ 30 Minutes ]**
Admin Instructions: Nurse to send medication(s) to operating room - To be administered by Anesthesiologist.To be given 1 hour prior to skin incision.
Priority: [ Routine ] **[ STAT ]** [ Timed ]

And

gentamicin (GARAMICIN) IVPB

Dose: [ 3 mg/kg ] **[ 5 mg/kg ]** [ 7 mg/kg ]
Weight Type: [ Recorded ] [ Ideal ] **[ Adjusted ]** [ Order-Specific ]
Route: **[ intravenous ]**
Frequency: **[ Once ]** [ Q24H ] [ Q36H ] [ Q48H ]
Admin Duration: **[ 30 Minutes ]** [ 60 Minutes ]
Admin Instructions: Nurse to send medication(s) to operating room - To be administered by Anesthesiologist.To be given 1 hour prior to skin incision.
Priority: [ Routine ] **[ STAT ]**

Antihypertensives

Default Phase of Care: L&D Pre-Delivery

[ ] labetalol (NORMODYNE) tablet

Dose: [ 100 mg ] **[ 200 mg ]** [ 300 mg ]
Route: **[ oral ]**
Frequency: **[ Once ]** [ Q8H SCH ] [ BID ]
Admin Instructions: For hypertension
Priority: **[ Routine ]**

Questions:

BP & HR HOLD parameters for this order: [ BP & HR HOLD Parameters requested ] **[ ONCE or PRN Orders - No Hold Parameters Needed ]**

Possible Cascading Questions:

If (answer is BP & HR HOLD Parameters requested):
BP & HR HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other Heart Rate):
Hold for Heart Rate LESS than (in bpm):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

[ ] hydrALAZINE (APRESOLINE) tablet

Dose: **[ 5 mg ]** [ 10 mg ] [ 25 mg ] [ 50 mg ] [ 75 mg ] [ 100 mg ]
Route: **[ oral ]**
Frequency: **[ Once ]** [ Q6H SCH ] [ Q8H SCH ] [ Q12H SCH ]
Admin Instructions: For hypertension.
Priority: **[ Routine ]**

Questions:

BP HOLD parameters for this order: [ BP Hold Parameters requested ] [ ONCE or PRN Orders - No Hold Parameters Needed ]

Possible Cascading Questions:

If (answer is BP Hold Parameters requested):
BP HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if:

PRN Severe Hypertension

[ ] NIFEdipine (PROCARDIA) capsule

Dose: **[ 10 mg ]** [ 20 mg ]
Route: **[ oral ]**
Frequency: **[ Once PRN ]** [ Once ]
For: 1 Doses
Admin Instructions:
Priority: **[ Routine ]**

Questions:

BP & HR HOLD parameters for this order: [ BP & HR HOLD Parameters requested ] [ ONCE or PRN Orders - No Hold Parameters Needed ]

Possible Cascading Questions:

If (answer is BP & HR HOLD Parameters requested):
BP & HR HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other Heart Rate):
Hold for Heart Rate LESS than (in bpm):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if: For Systolic BP GREATER than 160mmHG and Diastolic BP GREATER than 110mmHg

[ ] labetalol (NORMODYNE,TRANDATE) injection

Dose: [ 2.5 mg ] [ 5 mg ] [ 10 mg ] [ 15 mg ] **[ 20 mg ]** [ 40 mg ] [ 80 mg ]
Route: **[ intravenous ]**
Frequency: Once PRN
For: 1 Doses
Admin Instructions: Give IV Push over 2 minutes. Repeat BP measurements in 10 minutes and record results.
Priority: **[ Routine ]**

Questions:

BP & HR HOLD parameters for this order: [ BP & HR HOLD Parameters requested ] [ ONCE or PRN Orders - No Hold Parameters Needed ]

Possible Cascading Questions:

If (answer is BP & HR HOLD Parameters requested):
BP & HR HOLD for:
If (answer is Other Systolic BP):
Hold for Systolic BP LESS than (in mmHg):
If (answer is Other Heart Rate):
Hold for Heart Rate LESS than (in bpm):
If (answer is Other MAP):
Hold for Mean Arterial Pressure LESS than (in mmHG):
If (answer is Other Doppler BP (LVAD)):
Hold for Doppler Pressure (LVAD) LESS than (in mmHg):

Contact Physician if: For Systolic BP GREATER than 160mmHG and Diastolic BP GREATER than 110mmHg

## Non-Reassuring FHR with Tachysystole

[X] terbutaline (BRETHINE) injection

Dose: [ 0.125 mg ] **[ 0.25 mg ]** [ 0.5 mg ] [ 1 mg ]
Route: **[ subcutaneous ]**
Frequency: **[ Once PRN ]** [ Q15 Min ] [ Q20 Min ] [ Q15 Min PRN ] [ Q20 Min PRN ] [ Once ]
For: 1 Doses
Admin Instructions:
Priority: **[ Routine ]**

## Cervical Ripening

( ) Vaginal - misoprostol (CYTOTEC) tablet for vaginal use

Dose: **[ 25 mcg ]** [ 50 mcg ] [ 100 mcg ]
Route: vaginal
Frequency: [ Q3H ] **[ Q4H ]** [ Q6H ]
Admin Instructions: NIOSH recommends using single gloves when handling intact tabs or capsules.
Priority: **[ Routine ]**

( ) dinoprostone (CERVIDIL) vaginal insert

Dose: **[ 10 mg ]**
Route: **[ vaginal ]**
Frequency: **[ Once ]**
Admin Instructions: Remove Dinoprostone (Cervidil) 12 hours after placement (or if non-reassuring FHR tracing, tachysystole, onset of active labor). After insertion of Dinoprostone (Cervidil), position patient supine with lateral tilt for 2 hours
Priority: **[ Routine ]**

## Induction/Augmentation

( ) misoprostol (CYTOTEC) tablet for vaginal use

Dose: **[ 25 mcg ]**
Route: **[ vaginal ]**
Frequency: [ Q3H ] **[ Q4H ]** [ Q6H ]
Admin Instructions: NIOSH recommends using single gloves when handling intact tabs or capsules.
Priority: **[ Routine ]**

( ) Oxytocin Induction (Selection Required)

( ) Low Dose

Dose: **[ 2-40 milli-units/min ]** [ 4-40 milli-units/min ] [ 6-40 milli-units/min ]
Route: **[ intravenous ]**
Frequency: [ Continuous ] **[ Titrated ]**
Admin Instructions:

Begin 30 minutes after the removal of dinoprostone (CERVIDIL) insert OR begin 4 hours after the last dose of misoprostol (CYTOTEC).

In the absence of FHR abnormalities, start at 2 mu/min and increase by 2 mu/min every 15 minutes to a maximum of 40 milliunits/minute or until adequate uterine activity is achieved.

Adequate uterine activity is defined as: uterine contractions that are
2-3 minutes apart, contraction duration of 40-90 seconds and moderate intensity by palpation or 50-60 mmHg above baseline with IUPC. Contractions are not to exceed 5 contractions in 10 minutes averaged over a 30-minute window, last 2 minutes or more, occur within 1 minute of each other, or result in insufficient resting tone between contractions.

Priority: **[ Routine ]**

( ) High Dose - 4

Dose: [ 2-40 milli-units/min ] **[ 4-40 milli-units/min ]** [ 6-40 milli-units/min ]
Route: **[ intravenous ]**
Frequency: [ Continuous ] **[ Titrated ]**
Admin Instructions:
Begin 30 minutes after the removal of dinoprostone (CERVIDIL) insert OR begin 4 hours after the last dose of misoprostol (CYTOTEC).

In the absence of FHR abnormalities, start at 4 mu/min and increase by 4 mu/min every 15 minutes to a maximum of 40 milliunits/ minute or until adequate uterine activity is achieved.

Adequate uterine activity is defined as: uterine contractions that are
2-3 minutes apart, contraction duration of 40-90 seconds and moderate intensity by palpation or 50-60 mmHg above baseline with IUPC. Contractions are not to exceed 5 contractions in 10 minutes averaged over a 30-minute window, last 2 minutes or more, occur within 1 minute of each other, or result in insufficient resting tone between contractions.

Priority: **[ Routine ]**

( ) High Dose - 6

Dose: [ 2-40 milli-units/min ] [ 4-40 milli-units/min ] **[ 6-40 milli-units/min ]**
Route: **[ intravenous ]**
Frequency: [ Continuous ] **[ Titrated ]**
Admin Instructions:
Begin 30 minutes after the removal of dinoprostone (CERVIDIL) insert OR begin 4 hours after the last dose of misoprostol (CYTOTEC).

In the absence of FHR abnormalities, start at 6 mu/min and increase by 6 mu/min every 15 minutes to a maximum of 40 milliunits/minute or until adequate uterine activity is achieved.

Adequate uterine activity is defined as: uterine contractions that are
2-3 minutes apart, contraction duration of 40-90 seconds and moderate intensity by palpation or 50-60 mmHg above baseline with IUPC. Contractions are not to exceed 5 contractions in 10 minutes averaged over a 30-minute window, last 2 minutes or more, occur within 1 minute of each other, or result in insufficient restingtone between contractions.

Priority: **[ Routine ]**

PostPartum Oxytocin

[X] oxytocin (PITOCIN) Bolus and Maintenance Infusion (Selection Required)

oxytocin 30 unit/500 mL bolus from bag

Dose: **[ 10 Units ]** [ 167 mL ]
Route: **[ intravenous ]**
Frequency: **[ Once ]**
Admin Instructions:
Priority: **[ Routine ]**

Followed by

oxytocin (PITOCIN) infusion

Dose: **[ 5.7 Units/hr ]** [ 25 mL/hr ] [ 33.33 mL/hr ] [ 42 mL/hr ] [ 50 mL/hr ]
Route: **[ intravenous ]**
Frequency: **[ Continuous ]**
Starting: 30 Minutes after signing
Admin Instructions:
Run at 95 mL/hr for 3.5 hours. Total 20 units over 3.5 hours. (Infuse at rate of 95 mL/hr over 3.5 hours)
Increase to 999 mL/hr for uterine tone and bleeding per physician instructions.
Priority: **[ Routine ]**

Bleeding Medications PostPartum

( ) oxytocin (PITOCIN) infusion and methylergonovine (METHERGINE) (Selection Required)

methylergonovine (METHERGINE) is contraindicated if BP GREATER than 140/90 mmHg

oxytocin (PITOCIN) infusion

Dose: **[ 5.7 Units/hr ]** [ 25 mL/hr ] [ 33.33 mL/hr ] [ 42 mL/hr ] [ 50 mL/hr ]
Route: **[ intravenous ]**
Frequency: **[ Continuous PRN ]** [ Continuous ]
Admin Instructions: If uterine atony or if excessive bleeding persists, infuse oxytocin at 999mL/hr.
Priority: **[ Routine ]**

And

methylergonovine (METHERGINE) injection - Contraindicated if BP GREATER than 140/90 mmHg

Dose: **[ 200 mcg ]**

Route: **[ intramuscular ]** [ intravenous ]
Frequency: **[ Once PRN ]** [ Once ]
For: 1 Doses
Admin Instructions: Use if inadequate response to oxytocin. Notify Physician if further treatment needed. Contraindicated if BP GREATER than 140/90 mmHg
Priority: **[ Routine ]**

( ) oxytocin (PITOCIN) infusion AND carboprost (HEMABATE) injection And diphenoxylate-atropine (LOMOTIL) oral dose (Selection Required)

oxytocin (PITOCIN) infusion
Dose: **[ 5.7 Units/hr ]** [ 25 mL/hr ] [ 33.33 mL/hr ] [ 42 mL/hr ] [ 50 mL/hr ]
Route: **[ intravenous ]**
Frequency: **[ Continuous PRN ]** [ Continuous ]
Admin Instructions: If uterine atony or if excessive bleeding persists, infuse oxytocin at 999mL/hr.
Priority: **[ Routine ]**

And

carboprost (HEMABATE) injection
Dose: [ 100 mcg ] **[ 250 mcg ]**
Route: **[ intramuscular ]** [ Other ]
Frequency: **[ Once PRN ]** [ Once ]
For: 1 Doses
Admin Instructions:
Priority: **[ Routine ]**

And

diphenoxylate-atropine (LOMOTIL) 2.5-0.025 mg per tablet
Dose: **[ 1 tablet ]** [ 2 tablets ]
Route: **[ oral ]**
Frequency: **[ Once PRN ]** [ 4x Daily ] [ 4x Daily PRN ]
For: 1 Doses
Admin Instructions:
Priority: **[ Routine ]**

( ) oxytocin (PITOCIN) infusion and misoprostol (CYTOTEC) (Selection Required)

oxytocin (PITOCIN) infusion
Dose: **[ 5.7 Units/hr ]** [ 25 mL/hr ] [ 33.33 mL/hr ] [ 42 mL/hr ] [ 50 mL/hr ]
Route: **[ intravenous ]**
Frequency: **[ Continuous PRN ]** [ Continuous ]
Admin Instructions: If uterine atony or if excessive bleeding persists, infuse oxytocin at 999mL/hr
Priority: **[ Routine ]**

And

misoprostol (CYTOTEC) tablet
Dose: [ 400 mcg ] [ 600 mcg ] [ 800 mcg ] **[ 1,000 mcg ]**
Route: [ oral ] **[ rectal ]**
Frequency: **[ Once PRN ]** [ Once ]
For: 1 Doses
Admin Instructions: Use if inadequate response to oxytocin. Notify Physician if further treatment needed.
Priority: **[ Routine ]**

Fetal Demise

[ ] misoprostol (CYTOTEC) tablet
Dose: [ 400 mcg ] [ 600 mcg ] [ 800 mcg ]
Route: **[ oral ]** [ vaginal ]
Frequency: [ Once ] [ Q3H ] [ Q4H ] [ Q6H ] [ Q8H ] [ Q12H ]
Admin Instructions: NIOSH recommends using single gloves when handling intact tabs or capsules.
Priority: **[ Routine ]**

NALOXONE FOR LABOR ADMISSION OPIOID PAIN MEDICATIONS

[X] naloxone (NARCAN) 0.4 mg/mL injection
Dose:
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: [ Once ] **[ PRN ]**
Admin Instructions:
Priority: **[ Routine ]**

Moderate Pain (Pain Score 4-6) Only Appears If: **SB IP ORDERSET NOT HMSJ HMTW**

( ) fentaNYL (SUBLIMAZE) injection
Dose: 50 mcg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]

Frequency: [ Q1H PRN ] **[ Q2H PRN ]** [ Once ]
Admin Instructions:
Priority: **[ Routine ]**

Questions:
Allowance for Patient Preference: **[ Nurse may administer for higher level of pain per patient request (selection) ]** [ Nurse may administer for higher level of pain per patient request ] [ Do NOT allow for patient preference ]

( ) morPHINE injection
Dose: 2 mg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: **[ Once PRN ]** [ Once ] [ Q2H PRN ] [ Q3H PRN ] [ Q4H PRN ]
For: 1 Doses
Admin Instructions:
Priority: **[ Routine ]**

Questions:
Allowance for Patient Preference: **[ Nurse may administer for higher level of pain per patient request (selection) ]** [ Nurse may administer for higher level of pain per patient request ] [ Do NOT allow for patient preference ]

( ) nalbuphine (NUBAIN) injection
Dose: 5 mg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: Q4H PRN
Admin Instructions:
Priority: **[ Routine ]**

Questions:
Allowance for Patient Preference: **[ Nurse may administer for higher level of pain per patient request (selection) ]** [ Nurse may administer for higher level of pain per patient request ] [ Do NOT allow for patient preference ]

Moderate Pain (Pain Score 4-6) Only Appears If: **SB IP ORDERSET HMTW ONLY**

( ) fentaNYL (SUBLIMAZE) injection
Dose: 50 mcg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: [ Q1H PRN ] **[ Q2H PRN ]** [ Once ]
Admin Instructions:
Priority: **[ Routine ]**

Questions:
Allowance for Patient Preference: **[ Nurse may administer for higher level of pain per patient request (selection) ]** [ Nurse may administer for higher level of pain per patient request ] [ Do NOT allow for patient preference ]

( ) morPHINE injection
Dose: 2 mg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: **[ Once PRN ]** [ Once ] [ Q2H PRN ] [ Q3H PRN ] [ Q4H PRN ]
For: 1 Doses
Admin Instructions:
Priority: **[ Routine ]**

Questions:
Allowance for Patient Preference: **[ Nurse may administer for higher level of pain per patient request (selection) ]** [ Nurse may administer for higher level of pain per patient request ] [ Do NOT allow for patient preference ]

( ) nalbuphine (NUBAIN) injection
Dose: 5 mg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: Q4H PRN
Admin Instructions:
Priority: **[ Routine ]**

Questions:
Allowance for Patient Preference: **[ Nurse may administer for higher level of pain per patient request (selection) ]** [ Nurse may administer for higher level of pain per patient request ] [ Do NOT allow for patient preference ]

Moderate Pain (Pain Score 4-6) Only Appears If: **SB IP ORDERSET HMSJ ONLY**

( ) fentaNYL (SUBLIMAZE) injection

Dose: 50 mcg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: [ Q1H PRN ] **[ Q2H PRN ]** [ Once ]
Admin Instructions:
Priority: **[ Routine ]**

Questions:

Allowance for Patient Preference: **[ Nurse may administer for higher level of pain per patient request (selection) ]** [ Nurse may administer for higher level of pain per patient request ] [ Do NOT allow for patient preference ]

( ) morPHINE injection

Dose: 2 mg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: **[ Once PRN ]** [ Once ] [ Q2H PRN ] [ Q3H PRN ] [ Q4H PRN ]
For: 1 Doses
Admin Instructions:
Priority: **[ Routine ]**

Questions:

Allowance for Patient Preference: **[ Nurse may administer for higher level of pain per patient request (selection) ]** [ Nurse may administer for higher level of pain per patient request ] [ Do NOT allow for patient preference ]

( ) nalbuphine (NUBAIN) injection

Dose: 5 mg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: Q4H PRN
Admin Instructions:
Priority: **[ Routine ]**

Questions:

Allowance for Patient Preference: **[ Nurse may administer for higher level of pain per patient request (selection) ]** [ Nurse may administer for higher level of pain per patient request ] [ Do NOT allow for patient preference ]

Severe Pain (Pain Score 7-10) Only Appears If: **SB IP ORDERSET NOT HMTW**

( ) fentaNYL (SUBLIMAZE) injection

Dose: 100 mcg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: [ Q1H PRN ] **[ Q2H PRN ]** [ Once ]
Admin Instructions:
Priority: **[ Routine ]**

( ) morPHINE injection

Dose: 4 mg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: **[ Once PRN ]** [ Once ] [ Q2H PRN ] [ Q3H PRN ] [ Q4H PRN ]
For: 1 Doses
Admin Instructions:
Priority: **[ Routine ]**

( ) nalbuphine (NUBAIN) injection

Dose: 10 mg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: Q4H PRN
Admin Instructions:
Priority: **[ Routine ]**

Severe Pain (Pain Score 7-10) Only Appears If: **SB IP ORDERSET HMTW ONLY**

( ) fentaNYL (SUBLIMAZE) injection

Dose: 100 mcg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: [ Q1H PRN ] **[ Q2H PRN ]** [ Once ]
Admin Instructions:
Priority: **[ Routine ]**

( ) morPHINE injection

Dose: 4 mg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: **[ Once PRN ]** [ Once ] [ Q2H PRN ] [ Q3H PRN ] [ Q4H PRN ]
For: 1 Doses

Admin Instructions:
Priority: **[ Routine ]**

( ) nalbuphine (NUBAIN) injection
Dose: 10 mg
Route: **[ intravenous ]** [ intramuscular ] [ subcutaneous ]
Frequency: Q4H PRN
Admin Instructions:
Priority: **[ Routine ]**

Local Anesthetics - NOT HMTW Only Appears If: **SB IP ORDERSET NOT HMTW**

[X] lidocaine (XYLOCAINE) 10 mg/mL (1 %) injection
Dose:
Route: [ infiltration ] **[ intradermal ]**
Frequency: **[ PRN ]** [ Once ]
Admin Instructions: Specify site: perineal
Priority: **[ Routine ]**

Local Anesthetics - HMTW Only Only Appears If: **SB IP ORDERSET HMTW ONLY**

[X] lidocaine PF (XYLOCAINE) 10 mg/mL (1 %) injection
Dose:
Route: [ infiltration ] **[ intradermal ]**
Frequency: **[ PRN ]** [ Once ]
Admin Instructions: Specify Site: perineal
Priority: **[ Routine ]**

Antiemetics - HMH, HMSJ, HMW, HMSTC, HMTW Only Only Appears If: **SB IP ORDERSET HMH HMSJ HMW HMSTC HMTW ONLY**

[X] ondansetron (ZOFRAN) IV or Oral (Selection Required)

ondansetron ODT (ZOFRAN-ODT) disintegrating tablet
Dose: **[ 4 mg ]** [ 8 mg ] [ 16 mg ] [ 24 mg ]
Route: **[ oral ]**
Frequency: [ Once ] [ Q12H SCH ] **[ Q8H PRN ]**
Admin Instructions: Give if patient is able to tolerate oral medication.
Priority: **[ Routine ]**

Or

ondansetron (ZOFRAN) 4 mg/2 mL injection
Dose: **[ 4 mg ]** [ 8 mg ] [ 0.1 mg/kg ]
Route: **[ intravenous ]** [ intramuscular ]
Frequency: [ Once ] **[ Q8H PRN ]** [ Q12H ]
Admin Instructions: Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Priority: **[ Routine ]**

[X] promethazine (PHENERGAN) IV or Oral or Rectal (Selection Required)

promethazine (PHENERGAN) 12.5 mg IV
Dose: 12.5 mg
Route: intravenous
Frequency: Q6H PRN
Admin Instructions: Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.
Priority: **[ Routine ]**

Or

promethazine (PHENERGAN) tablet
Dose: **[ 12.5 mg ]** [ 25 mg ] [ 50 mg ]
Route: **[ oral ]**
Frequency: [ Q4H PRN ] **[ Q6H PRN ]**
Admin Instructions: Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.
Priority: **[ Routine ]**

Or

promethazine (PHENERGAN) suppository
Dose: **[ 12.5 mg ]** [ 25 mg ] [ 50 mg ]
Route: **[ rectal ]**
Frequency: [ Q4H PRN ] **[ Q6H PRN ]**
Admin Instructions: Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.
Priority: **[ Routine ]**

Or

promethazine (PHENERGAN) intraMUSCULAR injection
Dose: [ 6.25 mg ] **[ 12.5 mg ]**
Route: **[ intramuscular ]**
Frequency: [ Once ] [ Q4H PRN ] **[ Q6H PRN ]**
Admin Instructions: Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.
Priority: **[ Routine ]**

Antiemetics - HMSL, HMWB Only Only Appears If: **SB IP ORDERSET HMSL HMWB HMCY**

[X] ondansetron (ZOFRAN) IV or Oral (Selection Required)

ondansetron ODT (ZOFRAN-ODT) disintegrating tablet
Dose: **[ 4 mg ]** [ 8 mg ] [ 16 mg ] [ 24 mg ]
Route: **[ oral ]**
Frequency: [ Once ] [ Q12H SCH ] **[ Q8H PRN ]**
Admin Instructions: Give if patient is able to tolerate oral medication.
Priority: **[ Routine ]**

Or

ondansetron (ZOFRAN) 4 mg/2 mL injection
Dose: **[ 4 mg ]** [ 8 mg ] [ 0.1 mg/kg ]
Route: **[ intravenous ]** [ intramuscular ]
Frequency: [ Once ] **[ Q8H PRN ]** [ Q12H ]
Admin Instructions: Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Priority: **[ Routine ]**

[X] promethazine (PHENERGAN) IV or Oral or Rectal (Selection Required)

promethazine (PHENERGAN) injection
Dose: 12.5 mg
Route: intravenous
Frequency: Q6H PRN
Admin Instructions: Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.
Priority: **[ Routine ]**

Or

promethazine (PHENERGAN) tablet
Dose: **[ 12.5 mg ]** [ 25 mg ] [ 50 mg ]
Route: **[ oral ]**
Frequency: [ Q4H PRN ] **[ Q6H PRN ]**
Admin Instructions: Give if ondansetron (ZOFRAN) is ineffective and patient is able to tolerate oral medication.
Priority: **[ Routine ]**

Or

promethazine (PHENERGAN) suppository
Dose: **[ 12.5 mg ]** [ 25 mg ] [ 50 mg ]
Route: **[ rectal ]**
Frequency: [ Q4H PRN ] **[ Q6H PRN ]**
Admin Instructions: Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.
Priority: **[ Routine ]**

Antiemetics - HMSTJ Only Only Appears If: **SB IP ORDERSET HMSTJ ONLY**

[X] ondansetron (ZOFRAN) IV or Oral (Selection Required)

ondansetron ODT (ZOFRAN-ODT) disintegrating tablet
Dose: **[ 4 mg ]** [ 8 mg ] [ 16 mg ] [ 24 mg ]
Route: **[ oral ]**
Frequency: [ Once ] [ Q12H SCH ] **[ Q8H PRN ]**
Admin Instructions: Give if patient is able to tolerate oral medication.
Priority: **[ Routine ]**

Or

ondansetron (ZOFRAN) 4 mg/2 mL injection
Dose: **[ 4 mg ]** [ 8 mg ] [ 0.1 mg/kg ]
Route: **[ intravenous ]** [ intramuscular ]
Frequency: [ Once ] **[ Q8H PRN ]** [ Q12H ]
Admin Instructions: Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Priority: **[ Routine ]**

[X] promethazine (PHENERGAN) IVPB or Oral or Rectal (Selection Required)

promethazine (PHENERGAN) 25 mg in sodium chloride 0.9 % 50 mL IVPB

Dose: 12.5 mg
Route: intravenous
Frequency: Q6H PRN
Admin Instructions: Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.
Priority: **[ Routine ]**

Or

promethazine (PHENERGAN) tablet
Dose: **[ 12.5 mg ]** [ 25 mg ] [ 50 mg ]
Route: **[ oral ]**
Frequency: [ Q4H PRN ] **[ Q6H PRN ]**
Admin Instructions: Give if ondansetron (ZOFRAN) is ineffective and patient is able to tolerate oral medication.
Priority: **[ Routine ]**

Or

promethazine (PHENERGAN) suppository
Dose: **[ 12.5 mg ]** [ 25 mg ] [ 50 mg ]
Route: **[ rectal ]**
Frequency: [ Q4H PRN ] **[ Q6H PRN ]**
Admin Instructions: Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.
Priority: **[ Routine ]**

VTE

VTE Risk and Prophylaxis Tool (Selection Required) Only Appears If: **HM SB PROVIDERS**
VTE/DVT Risk Definitions - \\epic-nas.et0922.epichosted.com\static\OrderSets\VTE Risk Assessment Tool v7_MAK FINAL.pdf

( ) VERY LOW Risk of VTE

Very low risk of VTE
Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

And

Ambulate
Priority: **[ Routine ]**
Frequency: **[ TID ]** [ Until Discontinued ] [ Q Shift ] [ Daily ]
Order comments: Early ambulation
Scheduling Instructions:

Questions:
Specify: [ in hall ] [ in room ] [ with assistance ] [ with assistive device ]

Possible Cascading Questions:
If (answer is with assistive device):
Device:
If (answer is other (specify)):
Specify:

And

Avoid dehydration
Priority: **[ Routine ]**
Frequency: [ Once ] **[ Until Discontinued ]**
Starting: Today, At: N
Order comments:
Scheduling Instructions:

( ) LOW Risk of VTE

Anticipated admission LESS than or EQUAL to 72 hours.
Does not meet moderate or high risk criteria:
Moderate Risk High Risk
Anticipated or actual LOS admission GREATER than or EQUAL to 72 hours High risk thrombophilia with no prior VTE

Prior idiopathic, or estrogen related VTE
Low risk thrombophilia AND family hisotry of VTE OR single prior VTE
Receiving outpatient prophylactic LMWH or UFH

[X] Low risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

Low risk: **[ Due to low risk, SCDs are recommended while in bed and until fully ambulatory ]**

[X] Place sequential compression device (Selection Required)

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments: While in bed AND until fully ambulatory. Encourage early ambulation. Avoid dehydration.

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) MODERATE Risk of VTE (Selection Required)

Anticipated or actual LOS admission GREATER than 72 hours; does not meet High risk criteria. CONSIDER prophylactic LMWH/UFH (consult Anesthesia for delivery considerations)
High Risk
High risk thrombophilia with no prior VTE
Prior idiopathic, or estrogen related VTE
Low risk thrombophilia AND family hisotry of VTE OR single prior VTE
Receiving outpatient prophylactic LMWH or UFH

[X] Moderate Risk (Selection Required)

[X] Moderate risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Mechanical Prophylaxis (Selection Required) Only Appears If: **HM ORD SB NO ACTIVE SCD OR CONTRAINDICATION**

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments: SCD throughout hospitalization.  Encourage early ambulation. Avoid dehydration.

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) HIGH Risk of VTE (Selection Required)

High risk thrombophilia with no prior VTE
Prior idiopathic or estrogen related VTE
Low risk thrombophilia AND (family history of VTE OR single prior VTE)
Receiving outpatient prophylactic LMWH or UFH

[X] High Risk (Selection Required)

[X] High risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Mechanical Prophylaxis (Selection Required) Only Appears If: **HM ORD SB NO ACTIVE SCD OR CONTRAINDICATION**

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments: While in bed AND until fully ambulatory. Encourage early ambulation. Avoid dehydration.

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis with Risk Stratification (Selection Required)

( ) Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Selection Required) Only Appears If: **HM ORD SB SCD OR CONTRAINDICATION**

[X] Moderate risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No pharmacologic VTE prophylaxis because: **[ patient is already on therapeutic anticoagulation for other indication. ]**
Therapy for the following: [ Atrial fibrillation ] [ DVT ] [ PE ] [ Stroke prophylaxis ] [ Prosthetic heart valve ] [ Acute coronary syndrome (ACS) ] [ Hypercoagulable state ] [ Intra-aortic balloon pump (IABP) ] [ Ventricular Support Device ] [ Peripheral vascular disease (PVD) ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Other anticoagulant therapy:

[ ] Place sequential compression device (Selection Required)

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater

than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments:

Questions:
Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Selection Required) Only Appears If: **HM ORD SB NO ACTIVE SCD OR CONTRAINDICATION**

[X] Moderate risk of VTE
Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis
Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:
No pharmacologic VTE prophylaxis because: [ patient is already on therapeutic anticoagulation for other indication. ]
Therapy for the following: [ Atrial fibrillation ] [ DVT ] [ PE ] [ Stroke prophylaxis ] [ Prosthetic heart valve ] [ Acute coronary syndrome (ACS) ] [ Hypercoagulable state ] [ Intra-aortic balloon pump (IABP) ] [ Ventricular Support Device ] [ Peripheral vascular disease (PVD) ] [ Other ]

Possible Cascading Questions:
If (answer is Other):
Other anticoagulant therapy:

[X] Place sequential compression device (Selection Required)

( ) Contraindications exist for mechanical prophylaxis
Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:
No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments:

Questions:
Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Selection Required) Only Appears If: **HM ORD SB NO ACTIVE SCD OR CONTRAINDICATION**

[X] High risk of VTE
Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis
Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No pharmacologic VTE prophylaxis because: [ patient is already on therapeutic anticoagulation for other indication. ]
Therapy for the following: [ Atrial fibrillation ] [ DVT ] [ PE ] [ Stroke prophylaxis ] [ Prosthetic heart valve ] [ Acute coronary syndrome (ACS) ] [ Hypercoagulable state ] [ Intra-aortic balloon pump (IABP) ] [ Ventricular Support Device ] [ Peripheral vascular disease (PVD) ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Other anticoagulant therapy:

[X] Place sequential compression device (Selection Required)

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments:

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Selection Required) Only Appears If: **HM ORD SB SCD OR CONTRAINDICATION**

[X] High risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No pharmacologic VTE prophylaxis because: [ patient is already on therapeutic anticoagulation for other indication. ]
Therapy for the following: [ Atrial fibrillation ] [ DVT ] [ PE ] [ Stroke prophylaxis ] [ Prosthetic heart valve ] [ Acute coronary syndrome (ACS) ] [ Hypercoagulable state ] [ Intra-aortic balloon pump (IABP) ] [ Ventricular Support Device ] [ Peripheral vascular disease (PVD) ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Other anticoagulant therapy:

[ ] Place sequential compression device (Selection Required)

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments:

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

VTE Risk and Prophylaxis Tool Only Appears If: **HM SB NURSING AND PHARMACY**

VTE/DVT Risk Definitions - \\epic-nas.et0922.epichosted.com\static\OrderSets\VTE Risk Assessment Tool v7_MAK FINAL.pdf

( ) VERY LOW Risk of VTE

Very low risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

And

Ambulate

Priority: **[ Routine ]**
Frequency: **[ TID ]** [ Until Discontinued ] [ Q Shift ] [ Daily ]
Order comments: Early ambulation
Scheduling Instructions:

Questions:

Specify: [ in hall ] [ in room ] [ with assistance ] [ with assistive device ]

Possible Cascading Questions:

If (answer is with assistive device):
Device:
If (answer is other (specify)):
Specify:

And

Avoid dehydration

Priority: **[ Routine ]**
Frequency: [ Once ] **[ Until Discontinued ]**
Starting: Today, At: N
Order comments:
Scheduling Instructions:

( ) LOW Risk of VTE

Anticipated admission LESS than or EQUAL to 72 hours.
Does not meet moderate or high risk criteria:
Moderate Risk High Risk
Anticipated or actual LOS admission GREATER than or EQUAL to 72 hours High risk thrombophilia with no prior VTE

Prior idiopathic, or estrogen related VTE
Low risk thrombophilia AND family hisotry of VTE OR single prior VTE
Receiving outpatient prophylactic LMWH or UFH

[X] Low risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

Low risk: **[ Due to low risk, SCDs are recommended while in bed and until fully ambulatory ]**

[X] Place sequential compression device (Selection Required)

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]

Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments: While in bed AND until fully ambulatory. Encourage early ambulation. Avoid dehydration.

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) MODERATE Risk of VTE (Selection Required)

Anticipated or actual LOS admission GREATER than 72 hours; does not meet High risk criteria. CONSIDER prophylactic LMWH/UFH (consult Anesthesia for delivery considerations)
High Risk
High risk thrombophilia with no prior VTE
Prior idiopathic, or estrogen related VTE
Low risk thrombophilia AND family hisotry of VTE OR single prior VTE
Receiving outpatient prophylactic LMWH or UFH

[X] Moderate Risk (Selection Required)

[X] Moderate risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Mechanical Prophylaxis (Selection Required) Only Appears If: **HM ORD SB NO ACTIVE SCD OR CONTRAINDICATION**

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments: SCD throughout hospitalization. Encourage early ambulation. Avoid dehydration.

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) HIGH Risk of VTE (Selection Required)

High risk thrombophilia with no prior VTE
Prior idiopathic or estrogen related VTE
Low risk thrombophilia AND (family history of VTE OR single prior VTE)
Receiving outpatient prophylactic LMWH or UFH

[X] High Risk (Selection Required)

[X] High risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Mechanical Prophylaxis (Selection Required) Only Appears If: **HM ORD SB NO ACTIVE SCD OR CONTRAINDICATION**

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments: While in bed AND until fully ambulatory. Encourage early ambulation. Avoid dehydration.

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis with Risk Stratification (Selection Required)

( ) Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Selection Required) Only Appears If: **HM ORD SB SCD OR CONTRAINDICATION**

[X] Moderate risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No pharmacologic VTE prophylaxis because: [ patient is already on therapeutic anticoagulation for other indication. ]
Therapy for the following: [ Atrial fibrillation ] [ DVT ] [ PE ] [ Stroke prophylaxis ] [ Prosthetic heart valve ] [ Acute coronary syndrome (ACS) ] [ Hypercoagulable state ] [ Intra-aortic balloon pump (IABP) ] [ Ventricular Support Device ] [ Peripheral vascular disease (PVD) ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Other anticoagulant therapy:

[ ] Place sequential compression device (Selection Required)

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments:

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Selection Required) Only Appears If: **HM**

**ORD SB NO ACTIVE SCD OR CONTRAINDICATION**

[X] Moderate risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No pharmacologic VTE prophylaxis because: [ patient is already on therapeutic anticoagulation for other indication. ]
Therapy for the following: [ Atrial fibrillation ] [ DVT ] [ PE ] [ Stroke prophylaxis ] [ Prosthetic heart valve ] [ Acute coronary syndrome (ACS) ] [ Hypercoagulable state ] [ Intra-aortic balloon pump (IABP) ] [ Ventricular Support Device ] [ Peripheral vascular disease (PVD) ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Other anticoagulant therapy:

[X] Place sequential compression device (Selection Required)

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments:

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Selection Required) Only Appears If: **HM ORD SB NO ACTIVE SCD OR CONTRAINDICATION**

[X] High risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No pharmacologic VTE prophylaxis because: [ patient is already on therapeutic anticoagulation for other indication. ]
Therapy for the following: [ Atrial fibrillation ] [ DVT ] [ PE ] [ Stroke prophylaxis ] [ Prosthetic heart valve ] [ Acute coronary syndrome (ACS) ] [ Hypercoagulable state ] [ Intra-aortic balloon pump (IABP) ] [ Ventricular Support Device ] [ Peripheral vascular disease (PVD) ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Other anticoagulant therapy:

[X] Place sequential compression device (Selection Required)

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments:

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

( ) High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Selection Required) Only Appears If: **HM ORD SB SCD OR CONTRAINDICATION**

[X] High risk of VTE

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

[X] Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No pharmacologic VTE prophylaxis because: [ patient is already on therapeutic anticoagulation for other indication. ]
Therapy for the following: [ Atrial fibrillation ] [ DVT ] [ PE ] [ Stroke prophylaxis ] [ Prosthetic heart valve ] [ Acute coronary syndrome (ACS) ] [ Hypercoagulable state ] [ Intra-aortic balloon pump (IABP) ] [ Ventricular Support Device ] [ Peripheral vascular disease (PVD) ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Other anticoagulant therapy:

[ ] Place sequential compression device (Selection Required)

( ) Contraindications exist for mechanical prophylaxis

Priority: Routine
Frequency: **[ Once ]** [ Prior to Discharge ]
Order comments:

Questions:

No mechanical VTE prophylaxis due to the following contraindication(s): [ Bilateral Amputee ] [ Cellulitis, lymphangitis ] [ Compartment syndrome ] [ Current Hospice Patient ] [ Extreme leg deformity ] [ Gangene of lower extremity ] [ Leg edema greater than or equal to 3+ ] [ Lower extremity injury/trauma(i.e. fracture without cast, wounds) ] [ Severe lymphedema ] [ Severe peripheral neuropathy ] [ Severe peripheral vascular disease ] [ Suspected or confirmed DVT ] [ Surgical incision, leg ulceration ] [ Thrombophlebitis ]

(X) Place/Maintain sequential compression device continuous

Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Continuous ]**
Order comments:

Questions:

Side: [ Bilateral ] [ Left ] [ Right ]
Select Sleeve(s): [ Calf ] [ Foot ] [ Thigh ]

Labs

COVID-19 Qualitative PCR

[ ] COVID-19 qualitative RT-PCR - Nasal Swab

Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

Questions:

Specimen Source: **[ Nasal Swab ]** [ Nasopharyngeal Swab ]
Is this for pre-procedure or non-PUI assessment? **[ Yes ]** [ No ]

Possible Cascading Questions:

If (answer is No):
If HM ORD LQL COVID-19 AOE - EMPLOYED IN HEALTHCARE IS YES OR NO is satisfied:
Is the patient employed in healthcare with direct patient contact?
If HM ORD LQL COVID-19 AOE - EMPLOYED IN HEALTHCARE IS UNKNOWN is satisfied:
Is the patient employed in healthcare with direct patient contact?
Is the patient symptomatic for COVID-19 as defined by CDC?
If (answer is Yes):
Date of symptom onset:
If HM ORD LQL COVID-19 AOE - HOSPITALIZED IS YES is satisfied:
Is the patient hospitalized for COVID-19?
If HM ORD LQL COVID-19 AOE - HOSPITALIZED IS NO is satisfied:
Is the patient hospitalized for COVID-19?
If HM ORD LQL COVID-19 AOE - ICU IS YES is satisfied:
Is the patient admitted to ICU for COVID-19?
If HM ORD LQL COVID-19 AOE - ICU IS NO is satisfied:
Is the patient admitted to ICU for COVID-19?
If HM ORD LQL COVID-19 AOE - CONGREGATE CARE IS UNKNOWN is satisfied:
Is the patient a resident in a congregate (group) care setting?
If HM ORD LQL COVID-19 AOE - CONGREGATE CARE IS YES OR NO is satisfied:
Is the patient a resident in a congregate (group) care setting?
If HM ORD LQL COVID-19 AOE - PREGNANT IS YES OR NO is satisfied:
Is the patient pregnant?
If HM ORD LQL COVID-19 AOE - PREGNANT IS UNKNOWN is satisfied:
Is the patient pregnant?

If HM ORD LQL PATIENT LOCATION IS HMH HOSPITAL is satisfied:
Please select a reason for ordering, if applicable. Laboring patient
If HM ORD LQL PATIENT LOCATION IS A NON-HMH HOSPITAL is satisfied:
Please select a reason for ordering, if applicable. Laboring patient

## Labs

### [ ] Blood gas, arterial, cord

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

### [ ] Blood gas, venous, cord

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

### [ ] Rubella antibody, IgG

Frequency: **[ Once ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

### [ ] Surgical pathology request

Process Instructions:
A paper requisition will print when this order is submitted. The printout must accompany the specimen to the lab.
NOTE: If the specimen is a placenta, please only fill out the required "Surgical pathology request for placenta" order.
If the specimen is from twin placentas, please include identifiers for twin A and twin B (e.g. one clamp & two clamps, etc).
Order comments:

Questions:

Collection Date: Today
Collection Time:
Surgical Specimen:
Gestational Age:
Specimen Site:
Number of specimens:
Malignancy: [ Yes ] [ No ] [ Unknown ]
Irradiation: [ Yes ] [ No ] [ Unknown ]
Specimen Status: [ Fresh ] [ Formalin ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Other:

Chemotherapy: [ Yes ] [ No ] [ Unknown ]
Hormonal Therapy: [ Yes ] [ No ] [ Unknown ]
Clinical History:
Pre-Operative Diagnosis:
Procedure Type:

[ ] Urine drugs of abuse screen
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ Timed ] [ Add-on ]
Order comments:

[ ] Bedside glucose
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Once ]** [ Daily ] [ Q4H ] [ Q6H ] [ AC only ] [ AC & HS ] [ User Schedule ]
Order comments:
Scheduling Instructions:

[ ] OB Panel (Selection Required)

[ ] Bedside glucose
Priority: **[ Routine ]** [ STAT ]
Frequency: **[ Q1H ]** [ Once ] [ Daily ] [ Q4H ] [ Q6H ] [ AC only ] [ AC & HS ] [ User Schedule ]
Order comments:
Scheduling Instructions:

[X] CBC with platelet and differential-STAT
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[ ] CBC with platelet and differential- AM Draw repeats
Frequency: [ Once ] [ STAT ] [ AM Draw ] **[ AM Draw Repeats ]** [ Timed ] [ Add-on ]
For: 3 Days
Order comments:

[ ] Basic metabolic panel
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Hepatitis B surface antigen
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[ ] HIV 1/2 antigen/antibody, fourth generation, with reflexes
Frequency: **[ Once ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

Questions:
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.): [ Manual release ] [ Block release ]

Possible Cascading Questions:
If (answer is Manual release):
Reason for preventing immediate release:
Additional details for preventing immediate release:
If (answer is Block release):
Reason for preventing immediate release:
Additional details for preventing immediate release:

[X] Syphilis treponema screen with RPR confirmation (reverse algorithm)
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

Questions:
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.): [ Immediate ] [ Manual release ] [ Block release ]

Possible Cascading Questions:
If (answer is Manual release) Or (answer is Block release):
Reason for preventing immediate release:
Additional details for preventing immediate release:

[X] Type and screen, obstetrical patient

Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ Add-on ]
Order comments:

[X] Urinalysis screen and microscopy, with reflex to culture
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ Timed ] [ Add-on ]
Order comments: Specimen must be received in the laboratory within 2 hours of collection.

Questions:
Specimen Source: **[ Urine ]**
Specimen Site: [ Catheterized ] [ Clean catch ] [ Cystoscopy ] [ Foley ] [ Ileal conduit ] [ Kidney ] [ Koch pouch ] [ Midstream ] [ Nephrostomy ] [ Pediatric bag ] [ Random void ] [ Stint ] [ Suprapubic ] [ Ureteral ] [ VB1 ] [ VB2 ] [ VB3 ]

[ ] Pre-Eclamptic Lab Panel (Selection Required)

[X] CBC with differential
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Comprehensive metabolic panel
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Prothrombin time with INR
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Partial thromboplastin time
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:
Do not draw blood from the arm that has heparin infusion. Do not draw from heparin flushed lines. If there is no other access other than the heparin line, then stop the heparin, flush the line, and aspirate 20 ml of blood to waste prior to drawing a specimen.

[X] Fibrinogen
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Uric acid
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] LDH
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[ ] Urine Protein and Creatinine (Selection Required)

[X] Creatinine level, urine, random
Frequency: **[ Once ]** [ AM Draw ] [ Timed ] [ Add-on ]
Order comments:

[X] Protein, urine, random
Frequency: **[ Once ]** [ AM Draw ] [ Timed ] [ Add-on ]
Order comments:

[ ] Fetal Demise Panel (Selection Required)

[X] Antibody screen (gel)
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ Add-on ]
Order comments:

[X] Antithrombin III level
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Cardiolipin antibodies
Frequency: **[ Once ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[X] Factor V leiden by PCR
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

Questions:

Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.): [ Immediate ] [ Manual release ] [ Block release ]

Possible Cascading Questions:

If (answer is Manual release) Or (answer is Block release):

Reason for preventing immediate release:

Additional details for preventing immediate release:

[X] Fibrinogen

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]

Order comments:

[X] Hemoglobin A1c

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]

Order comments:

[X] Homocysteine, plasma

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]

Order comments:

[X] Kleihauer-Betke

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]

Order comments:

[X] Lupus anticoagulant panel

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]

Process Instructions: Reflex testing: if the PTT LA is positive, an order for Hexagonal Phospholipid will be reflexed. If the dRVVT is positive, an order for dRVVC will be reflexed.

Order comments:

[X] Parvovirus B19 antibody, IgG and IgM

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]

Order comments: This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

[X] Prothrombin mutation, factor II, by PCR

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]

Order comments:

Questions:

Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.): [ Immediate ] [ Manual release ] [ Block release ]

Possible Cascading Questions:

If (answer is Manual release) Or (answer is Block release):

Reason for preventing immediate release:

Additional details for preventing immediate release:

[X] Partial thromboplastin time

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]

Order comments:

Do not draw blood from the arm that has heparin infusion. Do not draw from heparin flushed lines. If there is no other access other than the heparin line, then stop the heparin, flush the line, and aspirate 20 ml of blood to
waste prior to drawing a specimen.

[X] Prothrombin time with INR

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]

Order comments:

[X] TSH

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]

Order comments:

OB Screening Markers

[ ] POC Amnisure

Frequency: **[ Once ]**

Order comments:

[ ] Amnisure

Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ Timed ] [ Add-on ]
Specimen Type: Amniotic fluid
Order comments:

[ ] POC AmnioTest

Frequency: **[ Once ]** [ Daily ] [ Q Shift ] [ BID ] [ TID ] [ 4x Daily ]
Order comments: Rule out ruptured membrane

[ ] Fern

Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ Timed ] [ Add-on ]
Specimen Type: Vaginal fluid
Order comments:

[ ] Fetal fibronectin

Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments: Deliver specimen immediately to the Core Laboratory.

[ ] POC nitrazine

Frequency: **[ Once ]**
Order comments:

## Microbiology

[ ] Neisseria gonorrhoeae, NAA

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

Questions:

Specimen Source: [ Endocervical Swab ] [ Male Urethral Swab ] [ Pap/Thin Prep ] [ Vaginal Swab ] [ Urine ] [ Rectal Swab ] [ Throat Swab ] [ Other ]
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.): [ Immediate ] [ Manual release ] [ Block release ]

Possible Cascading Questions:

If (answer is Manual release) Or (answer is Block release):
Reason for preventing immediate release:
Additional details for preventing immediate release:

[ ] Chlamydia trachomatis, NAA

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

Questions:

Specimen Source: [ Endocervical Swab ] [ Male Urethral Swab ] [ Pap/Thin Prep ] [ Vaginal Swab ] [ Urine ] [ Rectal Swab ] [ Throat Swab ] [ Other ]
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.): [ Immediate ] [ Manual release ] [ Block release ]

Possible Cascading Questions:

If (answer is Manual release) Or (answer is Block release):
Reason for preventing immediate release:
Additional details for preventing immediate release:

[ ] Chlamydia/Gonorrhoeae, NAA (for laboring mothers)

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

Questions:

Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.): [ Immediate ] [ Manual release ] [ Block release ]

Possible Cascading Questions:

If (answer is Manual release) Or (answer is Block release):
Reason for preventing immediate release:
Additional details for preventing immediate release:

## 24 Hour Urine

[ ] 24 Hour Urine (Selection Required)

[X] Creatinine clearance, urine, 24 hour

Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ Timed ] [ Add-on ]
Order comments:

[X] Protein, urine, 24 hour
Frequency: **[ Once ]** [ STAT ] [ AM Draw ] [ Timed ] [ Add-on ]
Order comments:

Magnesium and D-dimer

[ ] D-dimer
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

[ ] OB Magnesium Level
Frequency: [ Once ] **[ STAT ]** [ AM Draw ] [ AM Draw Repeats ] [ Timed ] [ Add-on ]
Order comments:

Cardiology

Imaging

Other Studies

Respiratory

Oxygen

[X] Oxygen therapy
Priority: **[ Routine ]** [ STAT ]
Frequency: [ Continuous ] **[ PRN ]**
Order comments: Continue O2 for 30 minutes per event.

Questions:
If 366 days and older:
Device: [ Nasal Cannula ] [ High Flow Nasal Cannula (HFNC) ] [ Heated High Flow ] **[ Non-rebreather mask ]** [ Trach Collar ] [ Venturi Mask ]
Rate in liters per minute: [ 6.5 Lpm ] [ 12 Lpm ] [ 13 Lpm ] [ 14 Lpm ] [ 15 Lpm ]
Titrate FiO2 to keep O2 Sat Above: [ 88 % ] [ 90% ] [ 92% ] [ 95% ] **[ Other (Specify) ]**
Specify titration to keep O2 Sat (%) Above: 94

Possible Cascading Questions:
If (answer is Nasal Cannula):
If 366 days and older:
Rate in liters per minute:
Titrate SpO2 to keep O2 Sat Above/Between:
If (answer is Other (Specify)):
Specify titration to keep O2 Sat (%) Above:
Titration Range Goals:
If (answer is Simple Face Mask):
Rate in liters per minute:
Titrate FiO2 to keep O2 Sat Above:
If (answer is Other (Specify)):
Specify titration to keep O2 Sat (%) Above:
If (answer is Non-rebreather mask):
Rate in liters per minute:
Titrate FiO2 to keep O2 Sat Above:
If (answer is Other (Specify)):
Specify titration to keep O2 Sat (%) Above:
If (answer is T-piece) Or (answer is Aerosol Mask) Or (answer is Face Tent) Or (answer is Trach Collar):
O2 %:
If (answer is Other (Specify)):
Specify O2 %:
Titrate FiO2 to keep O2 Sat Above:
If (answer is Other (Specify)):
Specify titration to keep O2 Sat (%) Above:
If (answer is Venturi Mask):
FiO2:
If (answer is Other (Specify)):
Specify O2 %:
Titrate FiO2 to keep O2 Sat Above:
If (answer is Other (Specify)):
Specify titration to keep O2 Sat (%) Above:
If (answer is Other (Specify)):
Specify:
Titrate FiO2 to keep O2 Sat Above:
If (answer is Other (Specify)):
Specify titration to keep O2 Sat (%) Above:
If (answer is High Flow Nasal Cannula (HFNC)):
If 366 days and older:
Rate in liters per minute:

If (answer is Heated High Flow):
Device:
If 366 days and older:
Rate in liters per minute:
If (answer is Other (Specify)):
Specify Flowrate (Lpm):
If 366 days and older:
O2 %:
If (answer is Other (Specify)):
Specify O2 %:

Indications for O2 therapy: **[ Fetal indication ]** [ Hypoxemia ] [ Increased work of breathing ] [ Respiratory distress ] [ Immediate post-op period ] [ Acute MI ] [ Cluster headaches ]

## Rehab

## Consults

For Physician Consult orders use sidebar

### Physician Consults

#### [ ] Consult Anesthesiology

Referral Info:
To Location/POS:
Number of Visits: 1
Expiration Date: S+365
Priority: **[ Routine ]** [ STAT ]
Order comments:

##### Questions:

Reason for Consult?

##### Conditional Questions:

If Class is Normal Or Class is Hospital Performed Or Class is HMWB Hospital Performed Or Class is HMW Hospital Performed Or Class is HMSTC Hospital Performed:

Patient/clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service notified ] [ Consultant not contacted ]

##### Possible Cascading Questions:

If (answer is Consultant not contacted):
Will you contact the consultant?
If (answer is No):
Best call back number (Personal contact number):
If (answer is Yes):
Best call back number (Personal contact number):
If (answer is Answering service notified):
Additional information:
Best call back number (Personal contact number):

If (Class is not HMWB Hospital Performed) And (Class is not HMW Hospital Performed) And (Class is not HMSTC Hospital Performed):

Patient/Clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service ]

##### Possible Cascading Questions:

If (answer is Answering service):
Additional information:
Best call back number (Personal contact number):

#### [ ] Consult Maternal and Fetal Medicine

Referral Info:
To Location/POS:
Number of Visits: 1
Expiration Date: S+365
Priority: **[ Routine ]** [ STAT ]
Order comments:
Referred to Provider Specialty: Maternal and Fetal Medicine

##### Questions:

Reason for Consult?

##### Conditional Questions:

If Class is Normal Or Class is Hospital Performed Or Class is HMWB Hospital Performed Or Class is HMW Hospital Performed Or Class is HMSTC Hospital Performed:

Patient/clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service notified ] [ Consultant not contacted ]

Possible Cascading Questions:

If (answer is Consultant not contacted):
Will you contact the consultant?
If (answer is No):
Best call back number (Personal contact number):
If (answer is Yes):
Best call back number (Personal contact number):
If (answer is Answering service notified):
Additional information:
Best call back number (Personal contact number):

If (Class is not HMWB Hospital Performed) And (Class is not HMW Hospital Performed) And (Class is not HMSTC Hospital Performed):
Patient/Clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service ]

Possible Cascading Questions:

If (answer is Answering service):
Additional information:
Best call back number (Personal contact number):

[ ] Consult Neonatology

Referral Info:
To Location/POS:
Number of Visits: 1
Expiration Date: S+365
Priority: **[ Routine ]** [ STAT ]
Order comments:
Referred to Provider Specialty: Neonatology

Questions:

Reason for Consult?

Conditional Questions:

If Class is Normal Or Class is Hospital Performed Or Class is HMWB Hospital Performed Or Class is HMW Hospital Performed Or Class is HMSTC Hospital Performed:
Patient/clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service notified ] [ Consultant not contacted ]

Possible Cascading Questions:

If (answer is Consultant not contacted):
Will you contact the consultant?
If (answer is No):
Best call back number (Personal contact number):
If (answer is Yes):
Best call back number (Personal contact number):
If (answer is Answering service notified):
Additional information:
Best call back number (Personal contact number):

If (Class is not HMWB Hospital Performed) And (Class is not HMW Hospital Performed) And (Class is not HMSTC Hospital Performed):
Patient/Clinical information communicated? [ Face to face ] [ Secure text ] [ Telephone ] [ Answering service ]

Possible Cascading Questions:

If (answer is Answering service):
Additional information:
Best call back number (Personal contact number):

Ancillary Consults

[ ] Consult to PT eval and treat

Process Instructions:
If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting physical therapy
If the patient currently has an order for bed rest, please consider revising the activity order to accommodate therapy
Priority: **[ Routine ]**
Order comments:

Questions:

Reasons for referral to Physical Therapy (mark all applicable): [ 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 ] [ Mobility Program for Ventilated patients ] [ Other ]

Possible Cascading Questions:

If (answer is Other):
Specify:

Are there any restrictions for positioning or mobility? [ Yes ] [ No ]

Possible Cascading Questions:

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

Please provide safe ranges for HR, BP, O2 saturation( if values are very abnormal):
Weight Bearing Status: [ LLE ] [ RLE ] [ LUE ] [ RUE ]

Possible Cascading Questions:

If (answer is LLE):
LLE Limitation:
If (answer is RLE):
RLE Limitation:
If (answer is LUE):
LUE Limitation:
If (answer is RUE):
RUE Limitation:

[ ] Consult to Social Work

Priority: **[ Routine ]** [ STAT ]
Order comments:

Questions:

Reason for Consult: [ Adoption ] [ Chemical Dependency ] [ Deaf ] [ Discharge Planning ] [ Fetal Demise ] [ Discharge Placement ] [ Hospice Referral ] [ SNF ] [ Suspected Abuse ] [ Suspected Domestic Violence ] [ Teen Pregnancy ] [ Human Trafficking ] [ Dialysis Placement ] [ SDOH ] [ Other Specify ]

Possible Cascading Questions:

If (answer is Other Specify):
Specify:
If (answer is Hospice Referral):
Evaluate for:
If (answer is SDOH):
Specify for SDOH:

[ ] Consult to Spiritual Care

Priority: **[ Routine ]** [ STAT ]
Frequency: Once
Order comments:
Process Instructions:
For urgent requests during office hours, contact the Chaplain's office.
For urgent requests after office hours, contact the ON CALL Chaplain.

Questions:

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

Possible Cascading Questions:

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

If (answer is Other Specify):
Specify:

## Additional Orders