

Location: _____

General

Admission or Observation (Required)

☐ **Admit to inpatient** Once, 1, Routine

Admitting Physician:

Level of Care:

Patient Condition:

Bed request comments:

Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

☐ **Admit to IP- University Teaching Service** Once, Routine

Admitting Physician:

Resident Physician:

Resident team assignment:

Level of Care:

Patient Condition:

Bed request comments:

Certification: I certify that based on my best clinical judgement and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

To reach the team taking care of this patient please call the University Teaching Service Answering Service at (713) 363-9648 and ask for the team taking care of the patient to be paged. The team name is listed in both "Treatment Teams" and "Notes from Clinical Staff" sections in the Summary\Overview tab of Epic.

☐ **Outpatient observation services under general supervision** Once, Routine

Admitting Physician:

Attending Provider:

Patient Condition:

Bed request comments:

☐ **UTS - Outpatient observation services under general supervision** Once, Routine

Admitting Physician:

Resident Physician:

Resident team assignment:

Patient Condition:

Bed request comments:

To reach the team taking care of this patient please call the University Teaching Service Answering Service at (713) 363-9648 and ask for the team taking care of the patient to be paged. The team name is listed in both "Treatment Teams" and "Notes from Clinical Staff" sections in the Summary\Overview tab of Epic.

☐ **Outpatient in a bed - extended recovery** Once, Routine

Admitting Physician:

Bed request comments:

Admission or Observation

Patient has active status order on file

☐ **Admit to inpatient** Once, 1, Routine

Admitting Physician:

Level of Care:

Patient Condition:

Bed request comments:

Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

☐ **Admit to IP- University Teaching Service** Once, Routine

Admitting Physician:

Resident Physician:

Resident team assignment:

Level of Care:

Patient Condition:

Bed request comments:

Certification: I certify that based on my best clinical judgement and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

To reach the team taking care of this patient please call the University Teaching Service Answering Service at (713) 363-9648 and ask for the team taking care of the patient to be paged. The team name is listed in both "Treatment Teams" and "Notes from Clinical Staff" sections in the Summary\Overview tab of Epic.

Sign: _____ Printed Name: _____ Date/Time: _____

☐ **Outpatient observation services under general supervision** Once, Routine

Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

☐ **UTS - Outpatient observation services under general supervision** Once, Routine

Admitting Physician:
Resident Physician:
Resident team assignment:
Patient Condition:
Bed request comments:

To reach the team taking care of this patient please call the University Teaching Service Answering Service at (713) 363-9648 and ask for the team taking care of the patient to be paged. The team name is listed in both "Treatment Teams" and "Notes from Clinical Staff" sections in the Summary\Overview tab of Epic.

☐ **Outpatient in a bed - extended recovery** Once, Routine

Admitting Physician:
Bed request comments:

Admission

Patient has active status order on file.

☐ **Admit to inpatient** Once, 1, Routine

Admitting Physician:
Level of Care:
Patient Condition:
Bed request comments:

Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

Admission or Observation (Required)

☐ **Admit to inpatient** Once, 1, Routine

Admitting Physician:
Level of Care:
Patient Condition:
Bed request comments:

Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

☐ **Outpatient observation services under general supervision** Once, Routine

Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

☐ **Outpatient in a bed - extended recovery** Once, Routine

Admitting Physician:
Bed request comments:

Admission or Observation

Patient has status order on file

☐ **Admit to inpatient** Once, 1, Routine

Admitting Physician:
Level of Care:
Patient Condition:
Bed request comments:

Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

☐ **Outpatient observation services under general supervision** Once, Routine

Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

☐ **Outpatient in a bed - extended recovery** Once, Routine

Admitting Physician:
Bed request comments:

Sign: _____ Printed Name: _____ Date/Time: _____

Observation Order

Patient has Inpatient status order on file and is Medicare. Place **Consult to Case Management for Status Change** order to evaluate for Code 44 status change to Observation

☐ **Consult to Case Management for Status Change** Once, Routine

Reason for status change:

Reason for Consult?

Observation Order

Patient has Inpatient status order on file. Are you sure you want to downgrade to Observation?

☐ **Outpatient observation services under general supervision** Once, Routine

Admitting Physician:

Attending Provider:

Patient Condition:

Bed request comments:

Admission Order

☒ **Admit to long term acute care facility** Once, Routine

Admitting Physician:

Bed request comments:

Certification: I certify that based on my best clinical judgement and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

Code Status (Required)

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

☒ **Code Status**

DNR and Modified Code orders should be placed by the responsible physician.

☐ **Full code** Continuous, Routine

Code Status decision reached by:

☐ **DNR (Do Not Resuscitate)** (Required)

☒ **DNR (Do Not Resuscitate)** Continuous, Routine

Did the patient/surrogate require the use of an interpreter?

Did the patient/surrogate require the use of an interpreter?

Does patient have decision-making capacity?

I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT

Active until Signed by the Responsible Attending Physician.:

Code Status decision reached by:

☐ **Consult to Palliative Care Service**

☒ **Consult to Palliative Care Service** Once, Routine

Priority:

Reason for Consult?

Order?

Name of referring provider:

Enter call back number:

Reason for Consult?

Note: Please call Palliative care office 832-522-8391. Due to current resource constraints, consultation orders received after 2:00 pm M-F will be seen the following business day. Consults placed over weekend will be seen on Monday.

☐ **Consult to Social Work** Once, Routine

Reason for Consult:

Reason for Consult?

☐ **Modified Code** Continuous, Routine

Did the patient/surrogate require the use of an interpreter?

Did the patient/surrogate require the use of an interpreter?

Does patient have decision-making capacity?

Modified Code restrictions:

I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT Active until Signed by the Responsible Attending Physician.:

Code Status decision reached by:

Sign: _____ Printed Name: _____ Date/Time: _____

☐ **Treatment Restrictions ((For use when a patient is NOT in a cardiopulmonary arrest))** Continuous - Treatment Restrictions, Routine

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.:

Treatment Restriction decision reached by:

Specify Treatment Restrictions:

Code Status decision reached by:

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.

☐ **Need time to evaluate patient for Code Status** Until discontinued, Routine

Isolation

☐ **Airborne isolation status**

☒ **Airborne isolation status** Continuous, Routine

☐ **Mycobacterium tuberculosis by PCR - If you suspect Tuberculosis, please order this test for rapid diagnostics.** Once, Routine

☐ **Contact isolation status** Continuous, Routine

☐ **Droplet isolation status** Continuous, Routine

☐ **Enteric isolation status** Continuous, Routine

Precautions

☐ **Aspiration precautions** Continuous, Routine

☐ **Fall precautions** Continuous, Routine

Increased observation level needed:

☐ **Latex precautions** Continuous, Routine

☐ **Seizure precautions** Continuous, Routine

Increased observation level needed:

Nursing

Vital signs

☒ **Vital signs - T/P/R/BP (per unit protocol)** Per unit protocol, Routine

Activity

☐ **Activity as tolerated** Until discontinued, Routine

Specify: ○ Activity as tolerated

☐ **Bed rest with bathroom privileges** Until discontinued, Routine

Bathroom Privileges: ○ with bathroom privileges

☐ **Out of bed, sit in chair (with assistance)** 2 times daily, S, Routine

Specify: ○ Activity as tolerated ○ Up with assistance

☐ **Out of bed, in chair and ambulate** 2 times daily, Routine

Specify: ○ Activity as tolerated ○ Up with assistance ○ Out of bed ○ Up in chair

☐ **Out of bed, encourage independent ambulation** Until discontinued, Routine

Specify: ○ Activity as tolerated ○ Out of bed

☐ **Weight bearing restrictions** Until discontinued, Routine

Weight Bearing Status:

Extremity:

☐ **Strict bed rest** Until discontinued, Routine

☐ **Up ad lib** Until discontinued, Routine

Specify: ○ Up ad lib

Sign: _____ Printed Name: _____ Date/Time: _____

Nursing Care

- ☐ **Daily weights** Daily, Routine
- ☐ **Intake and Output Qshift** Every shift, Routine
- ☐ **Nasogastric tube insert and maintain**
- ☒ **Nasogastric tube insertion** Once, Routine
Type:
- ☐ **Nasogastric tube maintenance** Until discontinued, Routine
Tube Care Orders:
- ☐ **Insert and maintain Foley**
- ☒ **Insert Foley catheter** Once, Routine
Type:
Size:
Urinometer needed:
Indication:
Foley catheter may be removed per nursing protocol.
- ☒ **Foley Catheter Care** Until discontinued, Routine
Orders: Maintain

Notify Physician

- ☒ **Notify Physician(vitals,output,pulse ox)** Until discontinued, Routine
- Temperature greater than: 100.5
Systolic BP greater than: 160
Systolic BP less than: 90
Diastolic BP greater than: 100
Diastolic BP less than: 50
Heart rate greater than (BPM): 100
Heart rate less than (BPM): 60
Respiratory rate greater than: 25
Respiratory rate less than: 8
SpO2 less than: 92
Temperature less than:
MAP less than: 60.000

Notify Physician- UTS

- ☐ **Notify Physician- Teaching Service** Until discontinued, Routine, To reach the team taking care of this patient please call the University Teaching Service Answering Service at (713) 363-9648 and ask for the team taking care of the patient to be paged. The team name is listed in both "Treatment Teams" and "Notes from Clinical Staff" sections in the Summary\Overview tab of Epic. If no response, page the Sr. Resident at 713- 768-0403. If no response is obtained using second pager, page the attending assigned to the patient.

Diet

- ☐ **NPO** Diet effective now, Routine
NPO:
Pre-Operative fasting options:
An NPO order without explicit exceptions means nothing can be given orally to the patient.
- ☐ **Diet** Diet effective now, Routine
Diet(s):
Cultural/Special:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

Tube Feed

Sign: _____ Printed Name: _____ Date/Time: _____

☐ **Tube feeding - Continuous** Continuous, Routine

Tube Feeding Schedule: ○ Continuous

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Schedule:

Dietitian to manage Tube Feed?

☐ **Tube feeding - Bolus** Diet effective now, Routine

Tube Feeding Schedule: ○ Bolus

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Schedule:

Dietitian to manage Tube Feed?

☐ **Tube feeding - Cyclic** Cyclic, Routine

Tube Feeding Schedule: ○ Cyclic

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Schedule:

Dietitian to manage Tube Feed?

IV Fluids**Peripheral IV Access**☒ **Initiate and maintain IV**☒ **Insert peripheral IV** Once, Routine☒ **sodium chloride 0.9 % flush** 10 mL, every 12 hours scheduled, line care☒ **sodium chloride 0.9 % flush** 10 mL, intravenous, PRN, line care**IV Bolus**☐ **electrolyte-A (PLASMA-LYTE A) bolus** 500 mL, intravenous, once, 1, Occurrences☐ **electrolyte-A (PLASMA-LYTE A) bolus** 1000 mL, intravenous, once, 1, Occurrences☐ **albumin human 5 % bottle** 12.5 g, intravenous, once, 15.000 Minutes

Indication:

☐ **albumin human 5 % bottle** 25 g, intravenous, once, 30.000 Minutes

Indication:

☐ **sodium chloride 0.9 % bolus 500 mL** 500 mL, intravenous, once, 1, Occurrences, 15.000 Minutes☐ **sodium chloride 0.9 % bolus 1000 mL** 1000 mL, intravenous, once, 1, Occurrences, 30.000 Minutes☐ **sodium bicarbonate 150 mEq in sterile water 1,000 mL infusion** 1000 mL, intravenous, once, 30.000 Minutes☐ **lactated ringer's bolus 500 mL** 500 mL, intravenous, once, 1, Occurrences, 15.000 Minutes☐ **lactated ringers bolus 1000 mL** 1000 mL, intravenous, once, 1, Occurrences, 30.000 Minutes

Sign: _____ Printed Name: _____ Date/Time: _____

Maintenance IV Fluids

- ☐ **sodium chloride 0.9 % infusion** 75 mL/hr, intravenous, once, 1, Occurrences
- ☐ **lactated Ringer's infusion** 75 mL/hr, intravenous, once, 1, Occurrences
- ☐ **dextrose 5 % and sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion** 75 mL/hr, intravenous, continuous
- ☐ **sodium chloride 0.45 % infusion** 75 mL/hr, intravenous, continuous
- ☐ **sodium chloride 0.45 % 1,000 mL with sodium bicarbonate 75 mEq/L infusion** 75 mL/hr, intravenous, continuous

Medications

For Analgesics, please refer to the General Pain Management order sets.

For Antihypertensives, please refer to the Hypertensive Urgency order set.

Antibiotics

- ☐ **azithromycin (ZITHROMAX) IV** intravenous, STAT

Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

Indication:

May cause QTc prolongation.

- ☐ **azithromycin (ZITHROMAX) tablet** 250 , oral, daily

Indication:

May cause QTc prolongation.

- ☐ **cefepime (MAXIPIME) IV** intravenous, every 8 hours, STAT

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Indication:

****EXTENDED INFUSION**** Administer over 3 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

- ☐ **ceftriaxone (ROCEPHIN) IV** intravenous, STAT

Indication:

Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

- ☐ **ciprofloxacin (CIPRO) IV** intravenous, STAT

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Indication:

May cause QTc prolongation.

- ☐ **ciprofloxacin (CIPRO) tablet** 500 , 2 times daily at 0600, 1600

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Indication:

May cause QTc prolongation.

If administering with tube feeds, mix with water to avoid interaction with tube feed

- ☐ **levofloxacin (LEVAQUIN) IV** intravenous, STAT

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

Indication:

May cause QTc prolongation.

- ☐ **levofloxacin (LEVAQUIN) tablet** 250 , oral, daily at 0600

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Indication:

If administering with tube feeds, mix with water to avoid interaction with tube feed

May cause QTc prolongation. Separate by 2 hours from any milk product, antacid, or iron.

- ☐ **meropenem (MERREM) IV** every 8 hours, STAT

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Indication:

****EXTENDED INFUSION**** Administer over 3 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

- ☐ **metronIDAZOLE (FLAGYL) IV** intravenous, STAT

Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

Indication:

- ☐ **metronIDAZOLE (FLAGYL) tablet** 250 , oral, 3 times daily

Indication:

Sign: _____ Printed Name: _____ Date/Time: _____

- ☐ **piperacillin-tazobactam (ZOSYN) IV** intravenous, every 8 hours, STAT

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Indication:

****EXTENDED INFUSION**** Administer over 4 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

- ☐ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

- ☒ **vancomycin (VANCOCIN) IV** intravenous, once, 1, Occurrences, STAT

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Indication:

LOADING DOSE

- ☒ **Pharmacy consult to manage vancomycin** Until discontinued, Routine

Indication:

Anticipated Duration of Vancomycin Therapy (Days):

All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

- ☐ **vancomycin (FIRVANQ) 50 mg/mL oral solution** 125 mg, oral, every 6 hours PRN, for Cdiff

Indication:

KEEP REFRIGERATED. SHAKE WELL

Antipyretics

- ☐ **ibuprofen tablet** 600 mg, oral, every 6 hours PRN, Fever GREATER than 100.5 F

Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

- ☐ **acetaminophen (TYLENOL) tablet** 650 mg, oral, every 6 hours PRN, Fever GREATER than 100.5 F, fever

Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

Shortness of Breath

- ☐ **albuterol (PROVENTIL) nebulizer solution** 2.5 mg, nebulization, Respiratory Therapy - every 4 hours

Aerosol Delivery Device:

- ☐ **albuterol (PROVENTIL) nebulizer solution** 2.5 mg, nebulization, every 4 hours PRN, shortness of breath

Aerosol Delivery Device:

- ☐ **ipratropium (ATROVENT) 0.02 % nebulizer solution** 0.5 mg, nebulization, Respiratory Therapy - every 4 hours

Aerosol Delivery Device:

- ☐ **ipratropium (ATROVENT) 0.02 % nebulizer solution** 0.5 mg, nebulization, every 4 hours PRN, shortness of breath

Aerosol Delivery Device:

- ☐ **ipratropium-albuterol (DUO-NEB) 0.5-2.5 mg/3 mL nebulizer solution** 3 mL, nebulization, Respiratory Therapy - every 4 hours

Aerosol Delivery Device:

- ☐ **ipratropium-albuterol (DUO-NEB) 0.5-2.5 mg/3 mL nebulizer solution** 3 mL, nebulization, every 4 hours PRN, shortness of breath

Aerosol Delivery Device:

PRN Blood Pressure Agents

- ☐ **hydrALAZINE (APRESOLINE) injection** 10 mg, intravenous, every 6 hours PRN, SBP GREATER than 180 mmHg, high blood pressure

BP HOLD parameters for this order:

Contact Physician if:

May be given IN ADDITION TO scheduled doses if needed.

- ☐ **enalaprilat (VASOTEC) injection** 1.25 mg, intravenous, every 6 hours PRN, SBP GREATER than 180 mmHg, high blood pressure

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

Contact Physician if:

Beta-Blockers

- ☐ **carvedilol (COREG) tablet** 6.25 mg, oral, 2 times daily

BP & HR HOLD parameters for this order:

Contact Physician if:

HOLD if systolic blood pressure is LESS THAN 90 millimeters of mercury OR if heart rate is EQUAL TO OR LESS THAN 55 beats per minute. Notify physician if medication is held. Give beta blockers with food and at least 2 hours apart from ACE Inhibitor or Angiotensin Receptor Blocker medication.

Sign: _____ Printed Name: _____ Date/Time: _____

- ☐ **metoprolol succinate XL (TOPROL-XL) 24 hr tablet** 25 mg, oral, daily

BP & HR HOLD parameters for this order:

Contact Physician if:

HOLD if systolic blood pressure is LESS THAN 90 millimeters of mercury OR if heart rate is EQUAL TO OR LESS THAN 55 beats per minute. Notify physician if medication is held. Give beta blockers with food and at least 2 hours apart from ACE Inhibitor or Angiotensin Receptor Blocker medication.

Do not crush or chew.

- ☐ **metoprolol tartrate (LOPRESSOR) tablet** 25 mg, oral, 2 times daily

BP & HR HOLD parameters for this order:

Contact Physician if:

HOLD if systolic blood pressure is LESS THAN 90 millimeters of mercury OR if heart rate is EQUAL TO OR LESS THAN 55 beats per minute. Notify physician if medication is held. Give beta blockers with food and at least 2 hours apart from ACE Inhibitor or Angiotensin Receptor Blocker medication.

Loop Diuretics

- ☐ **furosemide (LASIX) 20 mg injection** 20 mg, intravenous, 2 times daily at 0900, 1700
- ☐ **furosemide (LASIX) infusion** intravenous, continuous
- ☐ **bumetanide (BUMEX) 0.5 mg injection** 0.5 mg, intravenous, 2 times daily at 0900, 1700

Max dose 10 mg/day

Non-Loop Diuretics

- ☐ **spironolactone (ALDACTONE) tablet** 25 mg, oral, daily

BP HOLD parameters for this order:

Contact Physician if:

Nurse to check current serum Potassium level prior to Administration. Call MD if Potassium is greater than 5. HOLD DOSE FOR POTASSIUM LEVELS GREATER THAN 5. Avoid salt substitutes unless approved by MD.

- ☐ **eplerenone (INSPIRA) tablet** 25 mg, oral, daily

Nurse to check current serum Potassium level prior to Administration. Call MD if Potassium is greater than 5. HOLD DOSE FOR POTASSIUM LEVELS GREATER THAN 5. Avoid salt substitutes unless approved by MD.

- ☐ **metolazone (ZAROXOLYN) tablet** 5 mg, oral, daily

Nitrates

- ☐ **nitroglycerin (NITROSTAT) SL tablet** 0.4 mg, sublingual, every 5 min PRN, 3, Occurrences, chest pain

Contact physician if given.

- ☐ **isosorbide mononitrate (MONOKET) tablet** 20 , oral, 2 times daily

BP HOLD parameters for this order:

Contact Physician if:

- ☐ **nitroglycerin (NITROSTAT) 2 % ointment** 0.5 inch, Topical, every 6 hours scheduled

- ☐ **nitroglycerin patch** 0.2 mg, transdermal, daily

Remove before bedtime

- ☐ **isosorbide mononitrate (IMDUR) 24 hr tablet** 60 mg, oral, daily

BP HOLD parameters for this order:

Contact Physician if:

Do not crush or chew.

- ☐ **isosorbide dinitrate (ISORDIL) tablet** 20 mg, oral, 3 times daily at 0900, 1300, 1700

BP HOLD parameters for this order:

Contact Physician if:

- ☐ **nitroglycerin (TRIDIL) 200 mcg/mL in sodium chloride 0.9% 250 mL infusion** 5 mcg/min, continuous

HOLD if systolic blood pressure is LESS THAN 100 millimeters of mercury OR heart rate is LESS than 55 beats per minute.

Platelet Inhibitors

- ☐ **aspirin chewable 81 mg tablet** 81 mg, oral, daily

- ☐ **prasugrel (EFFIENT) tablet** (Required)

- ☒ **prasugrel (EFFIENT) tablet** 5 , oral, daily

Does this patient have a history of transient ischemic attack (TIA) or stroke?

Is the patient's age 75 years or older?

Is the patient's weight less than 60 kilograms?

- ☐ **ticagrelor (BRILINTA) tablet** 90 mg, oral, 2 times daily

Does the patient have active or a history of pathological bleeding (e.g., peptic ulcer or intracranial hemorrhage)?

Is the patient receiving maintenance aspirin dose greater than 100 mg/day?

Sign: _____ Printed Name: _____ Date/Time: _____

- ☐ **clopidogrel (PLAVIX) 75 mg tablet** 75 mg, oral, daily

Miscellaneous Agents

- ☐ **hydralazine 10 mg / isosorbide dinitrate 10 mg (BIDIL)**

- ☒ **hydrALAZINE (APRESOLINE) tablet** 10 mg, oral, 3 times daily

BP HOLD parameters for this order:

Contact Physician if:

To be taken with isosorbide dinitrate 10 mg oral tablet

- ☒ **isosorbide dinitrate (ISORDIL) tablet** 10 mg, oral, 3 times daily at 0900, 1300, 1700

BP HOLD parameters for this order:

Contact Physician if:

To be taken with hydralazine 10 mg oral tablet

Cough

- ☐ **guaifENesin (MUCINEX) 12 hr tablet** 600 mg, oral, 2 times daily PRN, cough

- ☐ **dextromethorphan-guaifenesin (MUCINEX DM REGULAR) 30-600 mg per 12 hr tablet** 1 tablet, oral, every 12 hours PRN, cough

Maximum: 4 tablets/24 hours

maximum: 4 tablets/24 hours

- ☐ **guaifENesin (ROBITUSSIN) 100 mg/5 mL syrup** 100 mg, oral, every 4 hours PRN, cough

- ☐ **dextromethorphan-guaifenesin (ROBITUSSIN-DM) 10-100 mg/5 mL liquid** 5 mL, oral, every 4 hours PRN, cough

- ☐ **codeine-guaifenesin (GUAIFENESIN AC) 10-100 mg/5 mL liquid** 5 mL, oral, every 4 hours PRN, cough

- ☐ **benzonatate (TESSALON) capsule** 100 mg, every 6 hours PRN, cough

HM IP MEDICATIONS - ADMISSION MEDICINE - CONSTIPATION FIRST LINE

- ☐ **polyethylene glycol (MIRALAX) packet 17 gram** 17 g, oral, daily PRN, constipation

Use as first line option for constipation.

Mix in 4-8oz of water.

- ☐ **docusate sodium (COLACE) capsule** 100 mg, oral, 2 times daily PRN, constipation

Use as first line option for constipation.

- ☐ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per tablet** 1 tablet, oral, daily PRN, constipation

Use as first line option for constipation.

- ☐ **bisacodyL (DULCOLAX) suppository** 10 mg, rectal, daily PRN, constipation

Use as first line option for constipation.

HM IP MEDICATIONS - ADMISSION MEDICINE - CONSTIPATION SECOND LINE

- ☐ **polyethylene glycol (MIRALAX) packet 17 gram** 17 g, oral, daily PRN, constipation

Use as second line option if constipation unrelieved by first line option.

Mix in 4-8oz of water.

- ☐ **docusate sodium (COLACE) capsule** 100 mg, oral, 2 times daily PRN, constipation

Use as second line option if constipation unrelieved by first line option.

- ☐ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per tablet** 1 tablet, oral, daily PRN, constipation

Use as second line option if constipation unrelieved by first line option.

- ☐ **bisacodyL (DULCOLAX) suppository** 10 mg, rectal, daily PRN, constipation

Use as second line option if constipation unrelieved by first line option.

Insomnia: For Patients LESS than 70 years old

- ☐ **zolpidem (AMBIEN) or ramelteon (ROZEREM) tablet nightly PRN sleep**

- ☐ **zolpidem (AMBIEN) tablet** 5 mg, oral, nightly PRN, sleep

- ☐ **ramelteon (ROZEREM) tablet** 8 mg, oral, nightly PRN, sleep

Insomnia: For Patients GREATER than or EQUAL to 70 years old

- ☐ **ramelteon (ROZEREM) tablet** 8 mg, oral, nightly PRN, sleep

Antiemetics

- ☒ **ondansetron (ZOFTRAN) IV or Oral (Required)**

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **ondansetron ODT (ZOFTRAN-ODT) disintegrating tablet** 4 mg, oral, every 8 hours PRN, nausea vomiting

Give if patient is able to tolerate oral medication.

May cause QTc prolongation.

☒ **ondansetron (ZOFTRAN) 4 mg/2 mL injection** 4 mg, intravenous, every 8 hours PRN, nausea vomiting

Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.

May cause QTc prolongation.

☐ **promethazine (PHENERGAN)**

☒ **promethazine (PHENERGAN) 12.5 mg IV** 12.5 mg, intravenous, every 6 hours PRN, nausea vomiting

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

☒ **promethazine (PHENERGAN) tablet** 12.5 mg, oral, every 6 hours PRN, nausea vomiting

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral medication.

☒ **promethazine (PHENERGAN) suppository** 12.5 mg, rectal, every 6 hours PRN, nausea vomiting

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral medication.

☒ **promethazine (PHENERGAN) intraMUSCULAR injection** 12.5 mg, intramuscular, every 6 hours PRN, nausea vomiting

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral medication.

Antiemetics

☒ **ondansetron (ZOFTRAN) IV or Oral (Required)**

☒ **ondansetron ODT (ZOFTRAN-ODT) disintegrating tablet** 4 mg, oral, every 8 hours PRN, nausea vomiting

Give if patient is able to tolerate oral medication.

May cause QTc prolongation.

☒ **ondansetron (ZOFTRAN) 4 mg/2 mL injection** 4 mg, intravenous, every 8 hours PRN, nausea vomiting

Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.

May cause QTc prolongation.

☐ **promethazine (PHENERGAN) IV or Oral or Rectal**

☒ **promethazine (PHENERGAN) injection** 12.5 mg, intravenous, every 6 hours PRN, nausea vomiting

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

☒ **promethazine (PHENERGAN) tablet** 12.5 mg, oral, every 6 hours PRN, nausea vomiting

Give if ondansetron (ZOFTRAN) is ineffective and patient is able to tolerate oral medication.

☒ **promethazine (PHENERGAN) suppository** 12.5 mg, rectal, every 6 hours PRN, nausea vomiting

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral medication.

Antiemetics

☒ **ondansetron (ZOFTRAN) IV or Oral (Required)**

☒ **ondansetron ODT (ZOFTRAN-ODT) disintegrating tablet** 4 mg, oral, every 8 hours PRN, nausea vomiting

Give if patient is able to tolerate oral medication.

May cause QTc prolongation.

☒ **ondansetron (ZOFTRAN) 4 mg/2 mL injection** 4 mg, intravenous, every 8 hours PRN, nausea vomiting

Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.

May cause QTc prolongation.

☐ **promethazine (PHENERGAN) IVPB or Oral or Rectal**

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **promethazine (PHENERGAN) 25 mg in sodium chloride 0.9 % 50 mL IVPB** 12.5 mg, intravenous, every 6 hours PRN, 30.000 Minutes, nausea

vomiting

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

☒ **promethazine (PHENERGAN) tablet** 12.5 mg, oral, every 6 hours PRN, nausea vomiting

Give if ondansetron (ZOFTRAN) is ineffective and patient is able to tolerate oral medication.

☒ **promethazine (PHENERGAN) suppository** 12.5 mg, rectal, every 6 hours PRN, nausea vomiting

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral medication.

Itching: For Patients GREATER than 70 years old

☒ **cetirizine (Zyrtec) tablet** 5 mg, oral, daily PRN, itching

Itching: For Patients LESS than 70 years old

☐ **diphenhydramine (BENADRYL) tablet** 25 mg, oral, every 6 hours PRN, itching

☐ **hydroxyzine (ATARAX) tablet** 10 mg, oral, every 6 hours PRN, itching

☒ **cetirizine (Zyrtec) tablet** 5 mg, oral, daily PRN, itching

☐ **fexofenadine (ALLEGRA) tablet - For eGFR LESS than 80 mL/min, reduce frequency to once daily as needed** 60 mg, oral, 2 times daily PRN, itching

GI Drugs

☐ **famotidine (PEPCID) IV or ORAL**

☒ **famotidine (PEPCID) injection** 20 mg, intravenous, 2 times daily, 2.000 mL

Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied: IV or ORAL

☒ **famotidine (PEPCID) tablet** 20 mg, oral, 2 times daily IV or ORAL

☐ **pantoprazole (PROTONIX) IV or Oral or Tube**

☒ **pantoprazole (PROTONIX) EC tablet** 40 mg, oral, daily at 0600

Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

☒ **pantoprazole (PROTONIX) 40 mg in sodium chloride 0.9 % 10 mL injection** 40 mg, intravenous, daily at 0600

Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied: Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

☒ **pantoprazole (PROTONIX) suspension** 40 mg, feeding tube, daily at 0600

Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

☐ **omeprazole (PRILOSEC) suspension** 2 , daily at 0600

Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

Separate administration with all other oral medications by 1 hour.

☐ **sucralfate (CARAFATE) Oral or NG Tube**

☒ **sucralfate (CARAFATE) tablet - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER**

1 g, oral, 4 times daily with meals and nightly

Take 1 hour before or 2 hours after meals**if ordered by Feeding tube Or PEG tube feeding should be stopped 1 hour before AND 1 hour after each dose.

☒ **sucralfate (CARAFATE) 100 mg/mL suspension - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER** 1 g, Nasogastric, 4 times daily with meals and nightly

Use with Nasogastric tubing. Use if patient is unable to swallow tablet.

Take 1 hour before or 2 hours after meals**if ordered by Feeding tube Or PEG tube feeding should be stopped 1 hour before AND 1 hour after each dose.

☐ **alum-mag hydroxide-simeth (MAALOX) 200-200-20 mg/5 mL suspension - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER** 30 mL, oral, every 4 hours PRN, indigestion

Do not give if patient is on hemodialysis or in chronic renal failure.

☐ **simethicone (MYLICON) chewable tablet** 80 mg, oral, every 4 hours PRN, 2, Occurrences, flatulence

GI Drugs

☐ **famotidine (PEPCID) IV or ORAL**

Sign: _____ Printed Name: _____ Date/Time: _____

- ☒ **famotidine (PEPCID) injection** 20 mg, intravenous, 2 times daily, 2.000 mL

Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
IV or ORAL

- ☒ **famotidine (PEPCID) tablet** 20 mg, oral, 2 times daily
IV or ORAL

- ☐ **pantoprazole (PROTONIX) IV or Oral or Tube**

- ☒ **pantoprazole (PROTONIX) EC tablet** 40 mg, oral, daily at 0600

Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

- ☒ **pantoprazole (PROTONIX) 40 mg in sodium chloride 0.9 % 10 mL injection** 40 mg, intravenous, daily at 0600

Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

- ☒ **pantoprazole (PROTONIX) suspension** 40 mg, feeding tube, daily at 0600

Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

- ☐ **sucralfate (CARAFATE) Oral or NG Tube**

- ☒ **sucralfate (CARAFATE) tablet - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER**

1 g, oral, 4 times daily with meals and nightly

Take 1 hour before or 2 hours after meals**if ordered by Feeding tube Or PEG tube feeding should be stopped 1 hour before AND 1 hour after each dose.

- ☒ **sucralfate (CARAFATE) 100 mg/mL suspension - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER** 1 g, Nasogastric, 4 times daily with meals and nightly

Use with Nasogastric tubing. Use if patient is unable to swallow tablet.

Take 1 hour before or 2 hours after meals**if ordered by Feeding tube Or PEG tube feeding should be stopped 1 hour before AND 1 hour after each dose.

- ☐ **alum-mag hydroxide-simeth (MAALOX) 200-200-20 mg/5 mL suspension - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER** 30 mL, oral, every 4 hours PRN, indigestion

Do not give if patient is on hemodialysis or in chronic renal failure.

- ☐ **simethicone (MYLICON) chewable tablet** 80 mg, oral, every 4 hours PRN, 2, Occurrences, flatulence

- ☐ **sodium chloride 0.9% bag for line care**

- ☒ **sodium chloride 0.9 % bag for line care** .9 , PRN, line care

For flushing of extension tubing sets after administration of intermittent infusions. Program sodium chloride bag to run at the same infusion rate as medication given for a total volume equal to contents of tubing sets used. Change bag every 96 hours.

VTE

Sign: _____ Printed Name: _____ Date/Time: _____

VTE Risk and Prophylaxis Tool (Required)

Low Risk Definition	Moderate Risk Definition Pharmacologic prophylaxis must be addressed. Mechanical prophylaxis is optional unless pharmacologic is contraindicated.	High Risk Definition Both pharmacologic AND mechanical prophylaxis must be addressed.
Age less than 60 years and NO other VTE risk factors	One or more of the following medical conditions :	One or more of the following medical conditions :
Patient already adequately anticoagulated	CHF, MI, lung disease, pneumonia, active inflammation, dehydration, varicose veins, cancer, sepsis, obesity, previous stroke, rheumatologic disease, sickle cell disease, leg swelling, ulcers, venous stasis and nephrotic syndrome	Thrombophilia (Factor V Leiden, prothrombin variant mutations, anticardiolipin antibody syndrome; antithrombin, protein C or protein S deficiency; hyperhomocysteinemia; myeloproliferative disorders)
	Age 60 and above	Severe fracture of hip, pelvis or leg
	Central line	Acute spinal cord injury with paresis
	History of DVT or family history of VTE	Multiple major traumas
	Anticipated length of stay GREATER than 48 hours	Abdominal or pelvic surgery for CANCER
	Less than fully and independently ambulatory	Acute ischemic stroke
	Estrogen therapy	History of PE
	Moderate or major surgery (not for cancer)	
	Major surgery within 3 months of admission	

Anticoagulation Guide for COVID patients ([https://formweb.com/files/houstonmethodist/documents/COVID-19 Anticoagulation Guideline - 8.20.2021v15.pdf](https://formweb.com/files/houstonmethodist/documents/COVID-19%20Anticoagulation%20Guideline%20-%208.20.2021v15.pdf))

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

☐ Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Required)

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **Moderate risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** (Required)

☒ **Moderate risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** (Required)

☒ **High risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** (Required)

☒ **High risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **LOW Risk of VTE** (Required)

☒ **Low Risk** (Required)

☒ **Low risk of VTE** Once, Routine

Low risk: ☐ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation ☐ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

☐ **MODERATE Risk of VTE - Surgical** (Required)

☒ **Moderate Risk** (Required)

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **Moderate risk of VTE** Once, Routine

☒ **Moderate Risk Pharmacological Prophylaxis - Surgical Patient** (Required)

☐ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☐ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily, S+1

If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

☐ **heparin**

Sign: _____ Printed Name: _____ Date/Time: _____

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **warfarin (COUMADIN)**

☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **MODERATE Risk of VTE - Non-Surgical (Required)**

☒ **Moderate Risk Pharmacological Prophylaxis - Non-Surgical Patient (Required)**

☒ **Moderate Risk (Required)**

☒ **Moderate risk of VTE** Once, Routine

☒ **Moderate Risk Pharmacological Prophylaxis - Non-Surgical Patient (Required)**

☐ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☐ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical (Required)**

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily

If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT), do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

☐ **heparin**

Sign: _____ Printed Name: _____ Date/Time: _____

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **warfarin (COUMADIN)**

☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine
No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **HIGH Risk of VTE - Surgical (Required)**

☒ **High Risk (Required)**

☒ **High risk of VTE** Once, Routine

☒ **High Risk Pharmacological Prophylaxis - Surgical Patient (Required)**

☐ **Contraindications exist for pharmacologic prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☐ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation (Required)**

Patient renal status: @CRCL@

Sign: _____ Printed Name: _____ Date/Time: _____

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily, S+1

If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

☐ **heparin**

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

Sign: _____ Printed Name: _____ Date/Time: _____

- ☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled
- ☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **warfarin (COUMADIN)**

- ☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

- ☐ **Medications**

- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

- ☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis** (Required)

- ☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

- ☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **HIGH Risk of VTE - Non-Surgical** (Required)

- ☒ **High Risk** (Required)

- ☒ **High risk of VTE** Once, Routine

- ☒ **High Risk Pharmacological Prophylaxis - Non-Surgical Patient** (Required)

- ☐ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

- ☐ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical** (Required)

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

- ☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

- ☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

Sign: _____ Printed Name: _____ Date/Time: _____

- ☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily

If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

- ☐ **heparin**

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

- ☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

- ☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

- ☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

- ☐ **Not high bleed risk**

- ☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

- ☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

- ☐ **warfarin (COUMADIN)**

- ☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

- ☐ **Medications**

- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

- ☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

- ☐ **Mechanical Prophylaxis (Required)**

- ☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

- ☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

- ☐ **HIGH Risk of VTE - Surgical (Hip/Knee) (Required)**

- ☒ **High Risk (Required)**

- ☒ **High risk of VTE** Once, Routine

- ☒ **High Risk Pharmacological Prophylaxis - Hip or Knee (Arthroplasty) Surgical Patient (Required)**

Sign: _____ Printed Name: _____ Date/Time: _____

☐ **Contraindications exist for pharmacologic prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis due to the following contraindication(s):

- ☐ **aspirin chewable tablet** 162 mg, daily, S+1
- ☐ **aspirin (ECOTRIN) enteric coated tablet** 162 mg, daily, S+1
- ☐ **Apixaban and Pharmacy Consult** (Required)

☒ **apixaban (ELIQUIS) tablet** 2.5 mg, 2 times daily, S+1
Indications: ○ VTE prophylaxis

☒ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy** Until discontinued, STAT
Indications: VTE prophylaxis

☐ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily, S+1

If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

☐ **heparin**

Sign: _____ Printed Name: _____ Date/Time: _____

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **Rivaroxaban and Pharmacy Consult (Required)**

☒ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission** 10 mg, daily at 0600 (TIME CRITICAL)

Indications: ☐ VTE prophylaxis

For Xarelto 15 mg and 20 mg, give with food or follow administration with enteral feeding to increase medication absorption. Do not administer via post-pyloric routes.

☒ **Pharmacy consult to monitor rivaroxaban (XARELTO) therapy** Until discontinued, STAT

Indications: VTE prophylaxis

Indication:

☐ **warfarin (COUMADIN)**

☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine
No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

Sign: _____ Printed Name: _____ Date/Time: _____

VTE Risk and Prophylaxis Tool

Low Risk Definition	Moderate Risk Definition Pharmacologic prophylaxis must be addressed. Mechanical prophylaxis is optional unless pharmacologic is contraindicated.	High Risk Definition Both pharmacologic AND mechanical prophylaxis must be addressed.
Age less than 60 years and NO other VTE risk factors	One or more of the following medical conditions :	One or more of the following medical conditions :
Patient already adequately anticoagulated	CHF, MI, lung disease, pneumonia, active inflammation, dehydration, varicose veins, cancer, sepsis, obesity, previous stroke, rheumatologic disease, sickle cell disease, leg swelling, ulcers, venous stasis and nephrotic syndrome	Thrombophilia (Factor V Leiden, prothrombin variant mutations, anticardiolipin antibody syndrome; antithrombin, protein C or protein S deficiency; hyperhomocysteinemia; myeloproliferative disorders)
	Age 60 and above	Severe fracture of hip, pelvis or leg
	Central line	Acute spinal cord injury with paresis
	History of DVT or family history of VTE	Multiple major traumas
	Anticipated length of stay GREATER than 48 hours	Abdominal or pelvic surgery for CANCER
	Less than fully and independently ambulatory	Acute ischemic stroke
	Estrogen therapy	History of PE
	Moderate or major surgery (not for cancer)	
	Major surgery within 3 months of admission	

Anticoagulation Guide for COVID patients ([https://formweb.com/files/houstonmethodist/documents/COVID-19 Anticoagulation Guideline - 8.20.2021v15.pdf](https://formweb.com/files/houstonmethodist/documents/COVID-19%20Anticoagulation%20Guideline%20-%208.20.2021v15.pdf))

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

☐ Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Required)

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **Moderate risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** (Required)

☒ **Moderate risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** (Required)

☒ **High risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** (Required)

☒ **High risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **LOW Risk of VTE** (Required)

☒ **Low Risk** (Required)

☒ **Low risk of VTE** Once, Routine

Low risk: ☐ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation ☐ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

☐ **Moderate Risk of VTE - Surgical** (Required)

☒ **Moderate Risk** (Required)

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **Moderate risk of VTE** Once, Routine

☒ **Moderate Risk Pharmacological Prophylaxis - Surgical Patient** (Required)

☐ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☐ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily, S+1

If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

☐ **heparin**

Sign: _____ Printed Name: _____ Date/Time: _____

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **warfarin (COUMADIN)**

☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **Moderate Risk of VTE - Non-Surgical (Required)**

☒ **Moderate Risk (Required)**

☒ **Moderate risk of VTE** Once, Routine

☒ **Moderate Risk Pharmacological Prophylaxis - Non-Surgical Patient (Required)**

☐ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

Sign: _____ Printed Name: _____ Date/Time: _____

- ☒ **Place/Maintain sequential compression device continuous** Continuous, Routine
Side: Bilateral
Select Sleeve(s):
- ☐ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**
- ☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis due to the following contraindication(s):
- ☒ **Contraindications exist for mechanical prophylaxis** Once, Routine
No mechanical VTE prophylaxis due to the following contraindication(s):
- ☐ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical** (Required)
Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

- ☐ **ENOXAPARIN 30 MG DAILY**
- ☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1
Indication(s):
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.
- ☐ **ENOXAPARIN SQ DAILY**
- ☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1
Indication(s):
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.
- ☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT), do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min
- ☐ **heparin**

Sign: _____ Printed Name: _____ Date/Time: _____

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **warfarin (COUMADIN)**

☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine
No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine
Side: Bilateral
Select Sleeve(s):

☐ **High Risk of VTE - Surgical (Required)**

Address both pharmacologic and mechanical prophylaxis by ordering from Pharmacological and Mechanical Prophylaxis.

☒ **High Risk (Required)**

☒ **High risk of VTE** Once, Routine

☒ **High Risk Pharmacological Prophylaxis - Surgical Patient (Required)**

☐ **Contraindications exist for pharmacologic prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☐ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation (Required)**

Patient renal status: @CRCL@

Sign: _____ Printed Name: _____ Date/Time: _____

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily, S+1

If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

☐ **heparin**

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

Sign: _____ Printed Name: _____ Date/Time: _____

- ☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled
- ☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **warfarin (COUMADIN)**

- ☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

☐ **Medications**

- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

- ☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **High Risk of VTE - Non-Surgical** (Required)

Address both pharmacologic and mechanical prophylaxis by ordering from Pharmacological and Mechanical Prophylaxis.

- ☒ **High Risk** (Required)

- ☒ **High risk of VTE** Once, Routine

- ☒ **High Risk Pharmacological Prophylaxis - Non-Surgical Patient** (Required)

- ☐ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

- ☐ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical** (Required)

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

- ☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

- ☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

- ☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily

If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

- ☐ **heparin**

Sign: _____ Printed Name: _____ Date/Time: _____

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **warfarin (COUMADIN)**

☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **High Risk of VTE - Surgical (Hip/Knee) (Required)**

Address both pharmacologic and mechanical prophylaxis by ordering from Pharmacological and Mechanical Prophylaxis.

☒ **High Risk (Required)**

☒ **High risk of VTE** Once, Routine

☒ **High Risk Pharmacological Prophylaxis - Hip or Knee (Arthroplasty) Surgical Patient (Required)**

☐ **Contraindications exist for pharmacologic prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☐ **aspirin chewable tablet** 162 mg, daily, S+1

☐ **aspirin (ECOTRIN) enteric coated tablet** 162 mg, daily, S+1

☐ **Apixaban and Pharmacy Consult (Required)**

☒ **apixaban (ELIQUIS) tablet** 2.5 mg, 2 times daily, S+1

Indications: ☐ VTE prophylaxis

☒ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy** Until discontinued, STAT

Indications: VTE prophylaxis

Sign: _____ Printed Name: _____ Date/Time: _____

☐ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily, S+1

If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

☐ **heparin**

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

Sign: _____ Printed Name: _____ Date/Time: _____

- ☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled
- ☐ **Not high bleed risk**
- ☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled
- ☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled
- ☐ **Rivaroxaban and Pharmacy Consult** (Required)
- ☒ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission** 10 mg, daily at 0600 (TIME CRITICAL)
Indications: ☐ VTE prophylaxis
For Xarelto 15 mg and 20 mg, give with food or follow administration with enteral feeding to increase medication absorption. Do not administer via post-pyloric routes.
- ☒ **Pharmacy consult to monitor rivaroxaban (XARELTO) therapy** Until discontinued, STAT
Indications: VTE prophylaxis
Indication:
- ☐ **warfarin (COUMADIN)**
- ☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700
Indication:
Dose Selection Guidance:
- ☐ **Medications**
- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine
Indication:
- ☐ **warfarin (COUMADIN) tablet** 1 , oral
Indication:
Dose Selection Guidance:

VTE Risk and Prophylaxis Tool

Low Risk Definition	Moderate Risk Definition Pharmacologic prophylaxis must be addressed. Mechanical prophylaxis is optional unless pharmacologic is contraindicated.	High Risk Definition Both pharmacologic AND mechanical prophylaxis must be addressed.
Age less than 60 years and NO other VTE risk factors	One or more of the following medical conditions :	One or more of the following medical conditions :
Patient already adequately anticoagulated	CHF, MI, lung disease, pneumonia, active inflammation, dehydration, varicose veins, cancer, sepsis, obesity, previous stroke, rheumatologic disease, sickle cell disease, leg swelling, ulcers, venous stasis and nephrotic syndrome	Thrombophilia (Factor V Leiden, prothrombin variant mutations, anticardiolipin antibody syndrome; antithrombin, protein C or protein S deficiency; hyperhomocysteinemia; myeloproliferative disorders)
	Age 60 and above	Severe fracture of hip, pelvis or leg
	Central line	Acute spinal cord injury with paresis
	History of DVT or family history of VTE	Multiple major traumas
	Anticipated length of stay GREATER than 48 hours	Abdominal or pelvic surgery for CANCER
	Less than fully and independently ambulatory	Acute ischemic stroke
	Estrogen therapy	History of PE
	Moderate or major surgery (not for cancer)	
	Major surgery within 3 months of admission	

Anticoagulation Guide for COVID patients ([https://formweb.com/files/houstonmethodist/documents/COVID-19 Anticoagulation Guideline - 8.20.2021v15.pdf](https://formweb.com/files/houstonmethodist/documents/COVID-19%20Anticoagulation%20Guideline%20-%208.20.2021v15.pdf))

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

☐ Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Required)

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **Moderate risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** (Required)

☒ **Moderate risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** (Required)

☒ **High risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** (Required)

☒ **High risk of VTE** Once, Routine

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **LOW Risk of VTE** (Required)

☒ **Low Risk** (Required)

☒ **Low risk of VTE** Once, Routine

Low risk: ☐ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation ☐ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

☐ **MODERATE Risk of VTE - Surgical** (Required)

☒ **Moderate Risk** (Required)

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **Moderate risk of VTE** Once, Routine

☒ **Moderate Risk Pharmacological Prophylaxis - Surgical Patient** (Required)

☐ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☐ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily, S+1

If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

☐ **heparin**

Sign: _____ Printed Name: _____ Date/Time: _____

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **warfarin (COUMADIN)**

☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **MODERATE Risk of VTE - Non-Surgical (Required)**

☒ **Moderate Risk Pharmacological Prophylaxis - Non-Surgical Patient (Required)**

☒ **Moderate Risk (Required)**

☒ **Moderate risk of VTE** Once, Routine

☒ **Moderate Risk Pharmacological Prophylaxis - Non-Surgical Patient (Required)**

☐ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**

☒ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

☐ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical (Required)**

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily

If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT), do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

☐ **heparin**

Sign: _____ Printed Name: _____ Date/Time: _____

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **warfarin (COUMADIN)**

☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine
No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **HIGH Risk of VTE - Surgical (Required)**

☒ **High Risk (Required)**

☒ **High risk of VTE** Once, Routine

☒ **High Risk Pharmacological Prophylaxis - Surgical Patient (Required)**

☐ **Contraindications exist for pharmacologic prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☐ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation (Required)**

Patient renal status: @CRCL@

Sign: _____ Printed Name: _____ Date/Time: _____

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily, S+1

If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

☐ **heparin**

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

Sign: _____ Printed Name: _____ Date/Time: _____

- ☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled
- ☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **warfarin (COUMADIN)**

- ☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

- ☐ **Medications**

- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

- ☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis** (Required)

- ☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

- ☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

☐ **HIGH Risk of VTE - Non-Surgical** (Required)

- ☒ **High Risk** (Required)

- ☒ **High risk of VTE** Once, Routine

- ☒ **High Risk Pharmacological Prophylaxis - Non-Surgical Patient** (Required)

- ☐ **Contraindications exist for pharmacologic prophylaxis** Once, Routine

No pharmacologic VTE prophylaxis due to the following contraindication(s):

- ☐ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical** (Required)

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

- ☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

- ☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

Sign: _____ Printed Name: _____ Date/Time: _____

- ☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily

If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

- ☐ **heparin**

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

- ☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

- ☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

- ☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

- ☐ **Not high bleed risk**

- ☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

- ☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

- ☐ **warfarin (COUMADIN)**

- ☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

- ☐ **Medications**

- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

- ☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

- ☐ **Mechanical Prophylaxis (Required)**

- ☐ **Contraindications exist for mechanical prophylaxis** Once, Routine

No mechanical VTE prophylaxis due to the following contraindication(s):

- ☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

- ☐ **HIGH Risk of VTE - Surgical (Hip/Knee) (Required)**

- ☒ **High Risk (Required)**

- ☒ **High risk of VTE** Once, Routine

- ☒ **High Risk Pharmacological Prophylaxis - Hip or Knee (Arthroplasty) Surgical Patient (Required)**

Sign: _____ Printed Name: _____ Date/Time: _____

☐ **Contraindications exist for pharmacologic prophylaxis** Once, Routine
No pharmacologic VTE prophylaxis due to the following contraindication(s):

- ☐ **aspirin chewable tablet** 162 mg, daily, S+1
- ☐ **aspirin (ECOTRIN) enteric coated tablet** 162 mg, daily, S+1
- ☐ **Apixaban and Pharmacy Consult** (Required)

☒ **apixaban (ELIQUIS) tablet** 2.5 mg, 2 times daily, S+1
Indications: ○ VTE prophylaxis

☒ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy** Until discontinued, STAT
Indications: VTE prophylaxis

☐ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** 30 mg, subcutaneous, daily at 1700, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** subcutaneous, S+1

Indication(s):

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** 2.5 mg, subcutaneous, daily, S+1

If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

☐ **heparin**

Sign: _____ Printed Name: _____ Date/Time: _____

High Risk Bleeding Characteristics
Age $\geq$ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

☐ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

☐ **HEParin (porcine) injection - Q12 Hours** 5000 Units, every 12 hours scheduled

☐ **HEParin (porcine) injection - Q8 Hours** 5000 Units, every 8 hours scheduled

☐ **Not high bleed risk**

☐ **Wt > 100 kg** 7500 Units, subcutaneous, every 8 hours scheduled

☐ **Wt LESS than or equal to 100 kg** 5000 Units, subcutaneous, every 8 hours scheduled

☐ **Rivaroxaban and Pharmacy Consult (Required)**

☒ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission** 10 mg, daily at 0600 (TIME CRITICAL)

Indications: ☐ VTE prophylaxis

For Xarelto 15 mg and 20 mg, give with food or follow administration with enteral feeding to increase medication absorption. Do not administer via post-pyloric routes.

☒ **Pharmacy consult to monitor rivaroxaban (XARELTO) therapy** Until discontinued, STAT

Indications: VTE prophylaxis

Indication:

☐ **warfarin (COUMADIN)**

☐ **WITHOUT pharmacy consult** 1 , oral, daily at 1700

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

☐ **warfarin (COUMADIN) tablet** 1 , oral

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Once, Routine
No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Continuous, Routine

Side: Bilateral

Select Sleeve(s):

Labs Today

Sign: _____ Printed Name: _____ Date/Time: _____

Hematology/Coagulation Today

☐ **CBC** Once, Routine, Blood, 3

CBC only; Does not include a differential

☐ **CBC and differential** Once, Routine, Blood, 3

☐ **Prothrombin time with INR** Once, Routine, Blood, 3

☐ **Partial thromboplastin time** Once, Routine, Blood, 3

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.

☐ **Anti Xa, unfractionated** Once, Routine, Blood, 3

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.

☐ **Sedimentation rate** Once, Routine, Blood, 3

Chemistry Today

☐ **Albumin** Once, Routine, Blood, 3

☐ **Amylase** Once, Routine, Blood, 3

☐ **Basic metabolic panel** Once, Routine, Blood, 3

☐ **NT-proBNP** Once, Routine, Blood, 3

☐ **CK total** Once, Routine, Blood, 3

☐ **Comprehensive metabolic panel** Once, Routine, Blood, 3

☐ **Hemoglobin A1c** Once, Routine, Blood, 3

☐ **Hepatic function panel** Once, Routine, Blood, 3

☐ **Lactic acid level - ONE TIME ORDER ONLY** Once, Routine, Blood, 3

SEPSIS PATIENTS:

FOR ALL SEPSIS OR SUSPECTED SEPSIS CHANGE FREQUENCY TO: NOW THEN EVERY 3 HOURS FOR 3 OCCURRENCES

☐ **Lipase** Once, Routine, Blood, 3

☐ **Lipid panel** Once, Routine, Blood, 3

☐ **Magnesium** Once, Routine, Blood, 3

☐ **Phosphorus** Once, Routine, Blood, 3

☐ **Prealbumin** Once, Routine, Blood, 3

☐ **TSH** Once, Routine, Blood, 3

☐ **T4, free** Once, Routine, Blood, 3

☐ **Uric acid** Once, Routine, Blood, 3

☐ **Urine drugs of abuse screen** Once, Routine, Urine

☐ **C-reactive protein** Once, Routine, Blood, 3

☐ **Procalcitonin** Once, Routine, Blood, 3

Cardiac

☐ **Troponin T : STAT** STAT, 1, Occurrences, Routine, Blood, 3

☐ **Troponin T : Now and every 6 hours x 2** Now then every 6 hours, 2, Occurrences, Routine, Blood, 3

☐ **Troponin T : Now and every 8 hours x 2** Now then every 8 hours, 2, Occurrences, Routine, Blood, 3

Microbiology

☐ **Blood culture, aerobic and anaerobic x 2**

☒ **Blood culture, aerobic and anaerobic x 2**

Most recent Blood Culture results from the past 7 days:

@LASTPROCRESULT(LAB462)@

Sign: _____ Printed Name: _____ Date/Time: _____

Blood Culture Best Practices (<https://formweb.com/files/houstonmethodist/documents/blood-culture-stewardship.pdf>)

☒ **Blood culture, aerobic & anaerobic** Once, Routine, Blood, Collect before antibiotics given. Blood cultures should be drawn from a peripheral site. If unable to draw both sets from a peripheral site, please call the lab for assistance; an IV line should NEVER be used.

☒ **Blood culture, aerobic & anaerobic** Once, Routine, Blood, Collect before antibiotics given. Blood cultures should be drawn from a peripheral site. If unable to draw both sets from a peripheral site, please call the lab for assistance; an IV line should NEVER be used.

☐ **Urinalysis screen and microscopy, with reflex to culture** Once, Routine, Urine, Not recommended for chronic Foley catheter patient or ESRD patient due to concerns of colonization

Specimen Source: Urine

Specimen Site:

Specimen must be received in the laboratory within 2 hours of collection.

☐ **Sputum culture** Once, Routine, Sputum

☐ **Respiratory Pathogen Panel with COVID-19** (Required)

☒ **Respiratory pathogen panel with COVID-19 RT-PCR** Once, Routine, Nasopharyngeal

☒ **Isolation** (Required)

Airborne plus Contact isolation is recommended for all Confirmed or Suspect COVID-19 patients regardless of aerosol generating procedure requirements in response to the OSHA standard published June 2021.

Please refer to the Confirmed COVID or PUI section in the [Clinical Resource Guide](#) for PPE guidance.

☒ **Airborne Isolation**

☒ **Airborne isolation status** Continuous, Routine, Include eye protection

☒ **Contact Isolation**

☒ **Contact isolation status** Continuous, Routine, Include eye protection

☐ **Influenza A and B, nucleic acid amplification**

☒ **Influenza A and B, nucleic acid amplification** Once, Routine

Specimen Source:

☒ **Droplet isolation status** Continuous, Routine

☐ **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**

☒ **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**

☒ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** Once, Routine, Nares

☒ **MRSA PCR has been ordered within 24 hours. Repeat testing is not indicated at this time.**

@LASTLAB(MRSAPCR)@

☐ **MRSA PCR has been ordered within 24 hours. Repeat testing is not indicated at this time.** Until discontinued, Routine

☒ **MRSA PCR has been ordered within the last 7 days. This test has shown to retain high negative predictive value within this time interval.**

@LASTLAB(MRSAPCR)@

☐ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** Once, Routine, Nares

☒ **This patient has a positive MRSA PCR result within the last 7 days.**

@LASTLAB(MRSAPCR)@

☐ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** Once, Routine, Nares

☒ **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**

@LASTLAB(MRSAPCR)@

☒ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** Once, Routine, Nares

Labs Tomorrow

Hematology/Coagulation Tomorrow

☐ **CBC** AM draw, 1, Occurrences, Routine, Blood, 3
CBC only; Does not include a differential

Sign: _____ Printed Name: _____ Date/Time: _____

- ☐ **CBC with differential** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Prothrombin time with INR** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Partial thromboplastin time** AM draw, 1, Occurrences, Routine, Blood, 3

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.

- ☐ **Anti Xa, unfractionated** AM draw, 1, Occurrences, Routine, Blood, 3

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.

Chemistry Tomorrow

- ☐ **Albumin** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Amylase** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Basic metabolic panel** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **NT-proBNP** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **CK total** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Comprehensive metabolic panel** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Hepatic function panel** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Lactic acid level - ONE TIME ORDER ONLY** AM draw, 1, Occurrences, Routine, Blood, 3

SEPSIS PATIENTS:

FOR ALL SEPSIS OR SUSPECTED SEPSIS CHANGE FREQUENCY TO: NOW THEN EVERY 3 HOURS FOR 3 OCCURRENCES

- ☐ **Lipase** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Lipid panel** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Magnesium** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Phosphorus** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Prealbumin** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **TSH** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **T4, free** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Uric acid** AM draw, 1, Occurrences, Routine, Blood, 3
- ☐ **Urine drugs of abuse screen** Once, S+1, Routine, Urine

Cardiology

Cardiology

- ☐ **Myocardial perfusion stress test** 1 time imaging, Routine, Must order Stress Test ECG Only order in conjunction.

What stress agent will be used? Regadenoson

Will this exam require to be scheduled as a one day or a two-day exam?

Patient's weight in pounds (lbs)?

Preferred interpreting Cardiologist or group:

- ☐ **Cv exercise treadmill stress (no imaging)** Once, Routine

What stress agent will be used? Regadenoson

Do you require imaging to be included? If yes, please select the appropriate imaging stress order:

What stress agent will be used?

- ☐ **ECG 12 lead - Routine** Once, Routine, 6

Clinical Indications: ○ Chest Pain

Interpreting Physician:

- ☐ **ECG 12 lead - STAT** Once, STAT, 6

Clinical Indications: ○ Chest Pain

Interpreting Physician:

Sign: _____ Printed Name: _____ Date/Time: _____

☐ **Echocardiogram complete w contrast and 3D if needed** 1 time imaging, Routine

Does this study require a chemo toxicity strain protocol?

Does this exam need a strain protocol?

Call back number for Critical Findings:

Where should test be performed?

Does this exam need a bubble study?

Preferred interpreting Cardiologist or group:

If this patient has had an echocardiogram ordered/performed within the past 120 hours as indicated by repeat Echo orders report on the left. Please contact the Echo department at 713-441-2222 to discuss the reason for a repeat exam with a cardiologist.

For STAT order, select appropriate STAT Indication. Please enter the cell phone number for the ordering physician so the echo attending can communicate the results of the stat test promptly. If the phone number is not entered, we will not be able to perform the test as stat. Please note that nursing unit phone number or NP phone number do not meet this request'

Other Indications should be ordered for TODAY or Routine.

For Discharge or Observation patient, please choose TODAY as Priority.

Imaging**MRI/MRA**☐ **MRI Brain Wo Contrast** 1 time imaging, Routine

Special Brain protocol requested?

Is this scan to monitor for ARIA during an Alzheimer Therapy?

ARIA Alzheimer therapy:

What are the patient's sedation requirements?

Is the patient pregnant?

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

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRI Brain W Contrast** 1 time imaging, Routine

Special Brain protocol requested?

What are the patient's sedation requirements?

Is the patient pregnant?

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

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRI Brain W Wo Contrast** 1 time imaging, Routine

Special Brain protocol requested?

What are the patient's sedation requirements?

Is the patient pregnant?

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

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRA Head Wo Contrast** 1 time imaging, Routine

What are the patient's sedation requirements?

Is the patient pregnant?

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

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRA Head W Contrast** 1 time imaging, Routine

What are the patient's sedation requirements?

Is the patient pregnant?

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

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRA Head W Wo Contrast** 1 time imaging, Routine

What are the patient's sedation requirements?

Is the patient pregnant?

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

☐ **MRA Neck Wo Contrast** 1 time imaging, Routine

What are the patient's sedation requirements?

Is the patient pregnant?

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

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRA Neck W Contrast** 1 time imaging, Routine

What are the patient's sedation requirements?

Is the patient pregnant?

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

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRA Neck W Wo Contrast** 1 time imaging, Routine

What are the patient's sedation requirements?

Is the patient pregnant?

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

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

CT☐ **CT Head Wo Contrast** 1 time imaging, Routine

Is the patient pregnant?

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

Sign: _____ Printed Name: _____ Date/Time: _____

☐ **CT Head W Contrast** 1 time imaging, Routine

Is the patient pregnant?

Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.

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

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☐ **CT Head W Wo Contrast** 1 time imaging, Routine

Is the patient pregnant?

Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.

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

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☐ **CT Chest Wo Contrast** 1 time imaging, Routine

Is the patient pregnant?

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

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☐ **CT Abdomen with IV and PO Contrast (Omnipaque)**

For those with iodine allergies, please order the panel with Read-Cat (barium sulfate).

☒ **CT Abdomen W Contrast** 1 time imaging, Routine

Is the patient pregnant?

Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.

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

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☒ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** 300 , once

FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Omnipaque)**

For those with iodine allergies, please order the panel with Read-Cat (barium sulfate).

☒ **CT Abdomen Pelvis W Contrast** 1 time imaging, Routine

Is the patient pregnant?

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

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☒ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** 300 , once

FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Read-Cat)**

Ordered as secondary option for those with iodine allergies.

☒ **CT Abdomen Pelvis W Contrast** 1 time imaging, Routine

Is the patient pregnant?

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

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☒ **barium (READI-CAT 2) 2.1 % (w/v), 2.0 % (w/w) suspension** 2 , once in imaging☐ **CT Pelvis W Contrast (Omnipaque)**

For those with iodine allergies, please order the panel with Read-Cat (barium sulfate).

Sign: _____ Printed Name: _____ Date/Time: _____

☒ **CT Pelvis W Contrast** 1 time imaging, Routine

Is the patient pregnant?

Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.

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

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☒ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** 300 , once

FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Omnipaque)**

For those with iodine allergies, please order the panel with Read-Cat (barium sulfate).

☒ **CT Abdomen Pelvis W Contrast** 1 time imaging, Routine

Is the patient pregnant?

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

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☒ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** 300 , once

FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Read-Cat)**

Ordered as secondary option for those with iodine allergies.

☒ **CT Abdomen Pelvis Wo Contrast** 1 time imaging, Routine

Is the patient pregnant?

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

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☒ **barium (READI-CAT 2) 2.1 % (w/v), 2.0 % (w/w) suspension** 2 , once in imaging☐ **CT Sinus Wo Contrast** 1 time imaging, Routine

Is the patient pregnant?

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

Sign: _____ Printed Name: _____ Date/Time: _____

X-Ray

☐ **Chest 1 Vw Portable** 1 time imaging, Routine

Is the patient pregnant?

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

☐ **Chest 1 Vw Portable** 1 time imaging, 1, Occurrences, STAT

Is the patient pregnant?

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

☐ **Chest 2 Vw** 1 time imaging, Routine

Is the patient pregnant?

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

☐ **Chest 2 Vw** 1 time imaging, 1, Occurrences, STAT

Is the patient pregnant?

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

☐ **KUB Kidney Ureter Bladder** 1 time imaging, Routine

Is the patient pregnant?

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

☐ **KUB Kidney Ureter Bladder** 1 time imaging, STAT

Is the patient pregnant?

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

☐ **Abdomen 2 Vw Ap W Upright And/Or Decubitus** 1 time imaging, Routine

Is the patient pregnant?

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

☐ **Abdomen 2 Vw Ap W Upright And/Or Decubitus** 1 time imaging, STAT

Is the patient pregnant?

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

Ultrasound

☐ **US Abdomen Complete** 1 time imaging, Routine

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

NPO 8 hours before exam.

☐ **US Gallbladder** 1 time imaging, Routine

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

NPO 8 hours before exam.

☐ **US Renal** 1 time imaging, Routine

Is the Ultrasound on a native kidney?

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

☐ **US Pelvis Complete** 1 time imaging, Routine

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

Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

☐ **US Pelvic Non Ob Limited** 1 time imaging, Routine

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

Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

☐ **US Pelvic Transvaginal** 1 time imaging, Routine

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

☐ **Pv carotid duplex** 1 time imaging, Routine

Laterality:

Special protocol:

☐ **Pv duplex arterial upper extremity** 1 time imaging, Routine

Laterality:

☐ **Pv duplex arterial lower extremity** 1 time imaging, Routine

Laterality:

☐ **Pv vascular screening** 1 time imaging, Routine

Other Studies

Respiratory

Respiratory

Sign: _____ Printed Name: _____ Date/Time: _____

☐ **Oxygen therapy - NC 2 Lpm** Continuous, Routine

Device: ○ Nasal Cannula

Rate in liters per minute: 2 lpm

Titrate to keep O2 Sat Above: 92%

Indications for O2 therapy: Hypoxemia

Device:

Indications for O2 therapy:

☐ **Incentive spirometry instructions** Once, Routine

Frequency of use:

Rehab

Consults

☐ **HM IP MEDICATIONS - ADMISSION MEDICINE - PHARMACY CONSULT PANEL**

☐ **Pharmacy consult to manage warfarin (COUMADIN)** Until discontinued, Routine

Indication:

☐ **Pharmacy Consult to Manage Heparin: STANDARD dose protocol (DVT/PE) - with titration boluses** Until discontinued,

Routine

Heparin Indication:

Specify:

Specify:

Monitoring:

Standard Dose Protocol

- IF ORDERED, Initial Bolus (80 units/kg) with no maximum.

- Consider in patients at risk for recurrent embolization.

- Initial Infusion (18 units/kg/hr) with no maximum.

- More aggressive titration with additional bolus and increase in heparin for sub-therapeutic monitoring levels.

See protocol for details

☐ **Pharmacy consult to manage Heparin: LOW Dose protocol(ACS/Stroke/Afib)- withOUT titration boluses** Until

discontinued, Routine

Heparin Indication:

Specify:

Monitoring: Anti-Xa

Low Dose Heparin Protocol

- IF ORDERED, Initial bolus (60 units/kg) up to a max of 5,000 units.

- Consider in patients at risk for bleeding.

- Initial infusion (12 units/kg/hr) up to a max of 1,000 units/hr initially.

- More conservative titration.

See protocol for details

Consult Pharmacy - Renal Dosing

☐ **Pharmacy consult to manage dose adjustments for renal function** Until discontinued, Routine

Adjust dose for:

Please assess for hemodialysis, peritoneal dialysis, or continuous renal replacement therapy (CRRT) orders in addition to creatine clearance when making dose adjustments.

Mobility Consults (Required)

☐ **Consult to PT eval and treat** Once, Routine

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

Are there any restrictions for positioning or mobility?

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

Weight Bearing Status:

Reason for PT?

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

Sign: _____ Printed Name: _____ Date/Time: _____

☐ **Consult to OT eval and treat** Once, Routine

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

Are there any restrictions for positioning or mobility?

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

Weight Bearing Status:

Reason for OT?

If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting occupational therapy

If the patient currently has an order for bed rest, please consider revising the activity order to accommodate therapy.

☐ **Patient does not require PT or OT at this time** Once, 1, Occurrences, Routine

Ancillary Consults

☐ **Consult to Case Management** Once, Routine

Consult Reason:

Reason for Consult?

☐ **Consult to Social Work** Once, Routine

Reason for Consult:

Reason for Consult?

☐ **Consult to PT Wound Care Eval and Treat** Once, Routine

Special Instructions:

Location of Wound?

Reason for PT?

☐ **Consult to Nutrition Services** Once, Routine

Reason For Consult?

Purpose/Topic:

Reason for Consult?

☐ **Consult to Spiritual Care** Once, Routine

Reason for consult?

Reason for Consult?

For requests after hours, call the house operator.

☐ **Consult to Speech Language Pathology** Once, Routine

Reason for consult:

Reason for SLP?

☐ **Consult to Wound Ostomy Care nurse** Once, Routine

Reason for consult:

Reason for consult:

Reason for consult:

Reason for consult:

Consult for NPWT:

Reason for consult:

Reason for consult:

Reason for Consult?

This is NOT for PT Wound Care Consult order.

☐ **Consult to Respiratory Therapy** Once, Routine

Reason for Consult?

Reason for Consult?

Additional Orders