Location: _____

Enhanced Recovery After Surgery (ERAS) Orders

☐ **ERAS Activity, Mutimodal Pain Management and Antiemetics**

☐ **ERAS Activity, Mutimodal Pain Management and Antiemetics**

☑ **ERAS - Activity**

☑ **Dangle at bedside** Once, Routine, Within 6 hours of extubation.

☑ **Activity - Out of bed to chair for all meals.** 3 times daily, Routine
Specify: ○ Out of bed ○ Up in chair
Additional modifier: all meals in chair

☑ **Ambulate** 4 times daily, S+1, Routine, Start ambulating on postop day 1, in the hallway as tolerated, with assistance if needed
Specify: ○ in hall ○ with assistance

☑ **ERAS Multimodal Pain Management**

☑ **dexmedeTOMIDine (PREcedex) infusion**

☑ **dexmedeTOMIDine (PREcedex) infusion** 0.2 mcg/kg/hr, intravenous, continuous, 24, Hours
DO NOT TITRATE. Hold infusion and notify provider immediately if HR less than 60 BPM or SBP less than 100 mmHg or any changes in mental status. Order can be titrated by ICU advanced practice provider/physician while in the CVICU and advance practice provider to change order back to 0.2 mcg/kg/hr and add end time of 24 hours when doing transfer orders to acute care telemetry.

☑ **acetaminophen (TYLENOL)**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients' maximum: 2 grams per day from all sources).

☑ **acetaminophen IV followed by oral**

☑ **acetaminophen (OFIRMEV) IV** 1000 mg, intravenous, once, 1, Occurrences
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
IV acetaminophen (Ofirmev) is restricted to use only in OR, PACU, or ICU areas, and for patients that cannot tolerate oral, per tube, or rectal routes of administration. Do you attest that this restriction has been met?
IV acetaminophen is restricted to use in patients that cannot tolerate oral, per tube, or rectal routes of administration, and is only approved for post-operative use. If patient status allows, please utilize an alternate route of administration of acetaminophen.
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

☐ **acetaminophen (TYLENOL)**

○ **Acetaminophen oral, per tube or rectal panel**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **acetaminophen (TYLENOL) tablet** 650 mg, oral, every 6 hours PRN, mild pain (score 1-3)
fever
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL)suspension** 650 mg, oral, every 6 hours PRN, mild pain (score 1-3)
fever
Use if patient cannot swallow tablet.

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

◉ **acetaminophen (TYLENOL) suppository** 650 mg, rectal, every 6 hours PRN, mild pain (score 1-3)
fever
Utilize this order to administer acetaminophen suppository if the patient cannot take medication by mouth or per tube.
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **Acetaminophen oral, per tube or rectal panel**

Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **acetaminophen (TYLENOL) tablet** 650 mg, oral, every 6 hours PRN, mild pain (score 1-3)
fever
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL)suspension** 650 mg, oral, every 6 hours PRN, mild pain (score 1-3)
fever
Use if patient cannot swallow tablet.

◉ **acetaminophen (TYLENOL) suppository** 650 mg, rectal, every 6 hours PRN, mild pain (score 1-3)
fever
Utilize this order to administer acetaminophen suppository if the patient cannot take medication by mouth or per tube.
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

☑ **Gabapentinoids**

○ **Gabapentin for patients GREATER than 65 years old**

○ **gabapentin (NEURONTIN) capsule 100 mg (CrCl greater than or equal to 60 mL/min)** 100 mg, oral, 3 times daily, 5, Days
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 100 mg (CrCl 30-59 mL/min)** 100 mg, oral, 2 times daily, 5, Days
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 100 mg (CrCl 15-29 mL/min)** 100 mg, oral, at bedtime, 5, Days
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **Gabapentin for patients LESS than 65 years old**

○ **gabapentin (NEURONTIN) capsule 300 mg (CrCl greater than or equal to 60 mL/min)** 300 mg, oral, 3 times daily
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 300 mg (CrCl 30-59 mL/min)** 300 mg, oral, 2 times daily
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 300 mg (CrCl 15-29 mL/min)** 300 mg, oral, at bedtime
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

☑ **Muscle Relaxant**

○ **Muscle Relaxant - Patients GREATER THAN or EQUAL TO 65 years old**

◉ **methocarbamoL (ROBAXIN) tablet** 250 mg, oral, 3 times daily, 6, Occurrences, Post-op

○ **cyclobenzaprine (FLEXERIL) tablet** 5 mg, oral, every 12 hours, Post-op

○ **Muscle Relaxant - Patients LESS THAN 65 years old**

◉ **methocarbamoL (ROBAXIN) tablet** 500 mg, oral, 3 times daily, 6, Occurrences, Post-op

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

○ **cyclobenzaprine (FLEXERIL) tablet** 5 mg, oral, 3 times daily, Post-op

☑ **Lidocaine Patch**

☑ **lidocaine 4 %** 1 patch, transdermal, every 24 hours, Post-op
Remove after 12 hours (do not give to patients with adhesive sensitivity or allergies to lidocaine). Apply to affected area. Remove patch 12 hours after applying.
Apply to affected area. Remove patch after specified duration.

☐ **ERAS - Ketamine for Pain Management for Post Cardiac Surgery (HMH ONLY)**

○ **ketamine (KETALAR) 10 mg/mL injection** 10 mg, intravenous, once, 1, Occurrences
Should only be ordered by ICU team (not CTS or other services); max cumulative dose 30 mg/24 hours

○ **ketamine (KETALAR) 10 mg/mL injection** 20 mg, intravenous, once, 1, Occurrences
Should only be ordered by ICU team (not CTS or other services); max cumulative dose 30 mg/24 hours

○ **ketamine (KETALAR) 10 mg/mL injection** 30 mg, intravenous, once, 1, Occurrences
Should only be ordered by ICU team (not CTS or other services); max cumulative dose 30 mg/24 hours

☑ **Opioids – PRN Only for moderate to severe breakthrough pain (pain score 4-10)**

◉ **traMADoL (ULTRAM) tablet** 50 mg, oral, every 6 hours PRN, Post-op, moderate pain (score 4-6)
Allowance for Patient Preference:
Give if patient can receive oral tablet/capsule.

○ **traMADoL (ULTRAM) tablet** 50 mg, oral, every 12 hours PRN, Post-op, moderate pain (score 4-6)
Allowance for Patient Preference:
Give if patient can receive oral tablet/capsule.

☑ **ERAS Antiemetics**

☑ **ondansetron (ZOFRAN) IV** 4 mg, intravenous, every 6 hours, 4, Occurrences, Post-op
Avoid use if QTc > 500 msec.
May cause QTc prolongation.

☑ **ondansetron (ZOFRAN) ODT or IV**

◉ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet** 4 mg, oral, every 8 hours PRN, nausea vomiting
Give if patient is able to tolerate oral medication. Avoid use if QTc > 500 msec.
May cause QTc prolongation.

◉ **ondansetron (ZOFRAN) IV** 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. Avoid use if QTc > 500 msec.
May cause QTc prolongation.

General

Elective Outpatient, Observation, or Admission

○ **Elective outpatient procedure: Discharge following routine recovery** Continuous, PACU & Post-op, Routine

○ **Outpatient observation services under general supervision** Once, PACU & Post-op, Routine
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

○ **Outpatient in a bed - extended recovery** Once, PACU & Post-op, Routine
Admitting Physician:
Bed request comments:

○ **Admit to Inpatient** Once, 1, PACU & Post-op, 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.

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

Admission or Observation

Patient has active outpatient status order on file

○ **Admit to Inpatient** Once, 1, PACU & Post-op, 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, PACU & Post-op, Routine
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

○ **Outpatient in a bed - extended recovery** Once, PACU & Post-op, Routine
Admitting Physician:
Bed request comments:

○ **Transfer patient** Once, Scheduling/ADT, Routine
Level of Care:
Bed request comments:

○ **Return to previous bed** Until discontinued, Scheduling/ADT, Routine

Admission

Patient has active status order on file

○ **Admit to inpatient** Once, 1, PACU & Post-op, 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.

○ **Transfer patient** Once, Scheduling/ADT, Routine
Level of Care:
Bed request comments:

○ **Return to previous bed** Until discontinued, Scheduling/ADT, Routine

Transfer

Patient has active inpatient status order on file

○ **Transfer patient** Once, Scheduling/ADT, Routine
Level of Care:
Bed request comments:

○ **Return to previous bed** Until discontinued, Scheduling/ADT, Routine

Code Status

@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**

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

☑ **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:

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

Precautions

☐ **Aspiration precautions** Continuous, Post-op, Routine

☐ **Fall precautions** Continuous, Post-op, Routine
Increased observation level needed:

☐ **Latex precautions** Continuous, Post-op, Routine

☐ **Seizure precautions** Continuous, Post-op, Routine
Increased observation level needed:

Nursing

Vital Signs

☐ **Vital signs - T/P/R/BP** Per unit protocol, Post-op, Routine

☐ **Hemodynamic Monitoring** Continuous, Post-op, Routine, Every hour if on drips. May go to Q4 hours after off of drips
Measure:

☐ **CVP monitoring** Continuous, Post-op, Routine, Monitor CVP continuously for VAD patients. DO NOT use CVP port for infusions.

☐ **Cardiac output monitoring** Continuous, Post-op, Routine
Record:

Activity

☐ **Strict bed rest** Until discontinued, Post-op, Routine

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

☐ **Activity - Out of bed to chair for all meals daily** 3 times daily, Post-op, Routine
Specify: ○ Other activity (specify)
Other: Out of bed to chair for all meals daily

☐ **Ambulate** 4 times daily, Post-op, Routine, In hallway as tolerated, with assistance if needed
Specify:

☐ **Dangle at bedside** Once, Post-op, Routine, Within 6 hours of extubation

☐ **Out of bed** Until discontinued, Post-op, Routine, Later in day on POD 1
Specify: ○ Out of bed

Nursing

☑ **Daily weights** Daily, Post-op, Routine

☐ **Chlorhexidine sage cloths** Once, Post-op, Routine, For patients who are unable to shower use cloths

☑ **Peripheral vascular assessment** Once, Post-op, Routine, Assess capillary refill, color, motion, sensation, edema and leg strength

☑ **Neurological assessment** Every hour, Post-op, Routine
Assessment to Perform: ○ Cranial Nerves ○ Glasgow Coma Scale ○ Level of Consciousness ○ Level of Sedation ○ Pupils

☑ **Measure drainage** Every hour, -1, Occurrences, Post-op, Routine
Type of drain: ○ Chest Tube

☑ **Incision Site Care**

☐ **Incision Site care** Per unit protocol, Routine
Site:

☑ **Apply warming blanket (bair hugger)** Once, Post-op, Routine, To achieve body temperature of 98.6 F

☑ **Foley catheter care** 2 times daily, Post-op, Routine, Clean with CHG cloths
Orders: Maintain

☑ **Chest tube to continuous suction** Until discontinued, Post-op, Routine
Level of suction: 20 cm H2O

☑ **Tube site care (chest tube)** Per unit protocol, Post-op, Routine, Chest tube site care daily and prn per protocol

☑ **Oral care** Every 4 hours, Post-op, Routine, Per CVICU protocol. When extubated change to toothbrush every 12 hours

☑ **Nasogastric tube maintenance (to low intermittent suction)** Until discontinued, Post-op, Routine
Tube Care Orders: ○ To Low Intermittent Suction

☑ **Nasogastric tube maintenance (remove NGT after extubation)** Once, 1, Occurrences, Post-op, Routine, Remove NGT after extubation
Tube Care Orders:

☐ **Nasogastric tube maintenance (Irrigate with 30ml NS)** Continuous, Post-op, Add-On, Irrigate with 30ml NS PRN to maintain patency
Tube Care Orders:

☐ **Gastric tube maintenance (to low intermittent suction)** Until discontinued, Post-op, Routine
Orders: to Low Intermittent Suction
Drainage:
Intervention:

☐ **Gastric tube maintenance (remove OGT after extubtion)** Until discontinued, Post-op, Routine, Remove OGT after extubation
Drainage:
Intervention:

☐ **Apply ace wrap** Once, Post-op, Routine
Specify location: ○ on leg where leg veins are harvested

☑ **Bedside glucose** Every hour, Post-op, Routine, Blood, Monitor every hour for first 6 hours post-operative. After 6 hours if insulin drip not started, change blood glucose monitoring to every 4 hours. Notify physician for blood glucose LESS than 70 mg/dL OR blood glucose GREATER or EQUAL to 180 mg/dL, if not on insulin drip. If blood glucose is GREATER or EQUAL to 180 mg/dL for 2 consecutive readings, notify physician (to reconcile orders) and start Cardiac Surgery Insulin Drip Order Set for Target Blood Glucose 140-180 mg/dL, starting at Algorithm 3.

☐ **Bedside glucose** Every 2 hours, Post-op, Routine, Blood, Monitor every 2 hours x 3 then every 4 hours. Notify physician for blood glucose LESS than 70 mg/dL OR blood glucose GREATER than or EQUAL to 180 mg/dL

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

☐ **Bedside glucose** Every 4 hours, Post-op, Routine, Blood, Every 4 hours; Notify physician for blood glucose LESS than 70 mg/dL OR blood glucose GREATER or EQUAL to 180 mg/dL

☐ **Pacemaker settings** Until discontinued, Post-op, Routine
Atrial Setting (MA):
Ventrical Setting (MA):
Sensitivity Setting (millivolts):
AV Interval (milliseconds):
Options:

☐ **Intra Aortic Balloon Pump Setting** Until discontinued, Post-op, Routine
Ratio:

Discontinue

☑ **Discontinue arterial line** Conditional Frequency, 1, Occurrences, Post-op, Routine, Before transfer out of ICU; if arterial line not already discontinued

☑ **Discontinue Pulmonary Artery Catheter/Cordis** Conditional Frequency, 1, Occurrences, Post-op, Routine, Before transfer out of ICU; if not already discontinued.

☑ **Discontinue Cardiac Monitor** Until discontinued, Post-op, Routine, Before transfer out of ICU; if not already discontinued.

☑ **Remove Foley catheter** Conditional Frequency, 1, Occurrences, Post-op, Routine, 1) Remove Foley cath POD 1 or POD 2; If unable to remove Foley reason for not removing MUST be documented on POD 1 or POD 2.

☑ **Discontinue arterial line (patient with more than 1 arterial line)** Conditional Frequency, 1, Occurrences, Post-op, Routine, For patients with more than one arterial line: DC femoral arterial line on POD 1.

☐ **Discontinue Pacemaker Generator and Insulate Pacer Wires** Conditional Frequency, 1, Occurrences, Post-op, Routine, Before transfer out of ICU; if not already discontinued.

Notify

☑ **Notify Physician for vitals:** Until discontinued, Post-op, Routine
Temperature greater than: ○ 102.5 ○ 100.5
Temperature less than: ○ 95
Systolic BP greater than: ○ 140 ○ 160
Systolic BP less than: ○ 80 ○ 90
Heart rate greater than (BPM): ○ 110 ○ 100
Heart rate less than (BPM): 60
Respiratory rate greater than: ○ 30 ○ 25
SpO2 less than: ○ 95 ○ 92
Diastolic BP greater than: 100
Diastolic BP less than: 50
MAP less than: 60.000
Respiratory rate less than: 8

☑ **Notify Physician-For CI less than 2.2, SVR greater than 1800 or less than 600, SVO2 less than 50** Until discontinued, Post-op, Routine, For CI less than 2.2, SVR greater than 1800 or less than 600, SVO2 less than 50

☑ **Notify Physician -For CVP less than 8 or greater than 15** Until discontinued, Post-op, Routine, For CVP less than 8 or greater than 15

☑ **Notify Physician-For chest output greater than 200 mililiters/hour** Until discontinued, Post-op, Routine, For chest output greater than 200 mililiters/hour

☐ **Notify Physician-If IABP alarm or change in neurovascular status** Until discontinued, Post-op, Routine, If IABP alarm or change in neurovascular status

☐ **Notify Physician-For urine output LESS THAN 0.5mL/kg per hour x 2 consecutive hours** Until discontinued, Post-op, Routine, For urine output LESS THAN 0.5mL/kg per hour x 2 consecutive hours.

Diet

☐ **NPO** Diet effective now, Post-op, Routine, Until extubated
NPO: ○ Except meds
Pre-Operative fasting options:
An NPO order without explicit exceptions means nothing can be given orally to the patient.

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

☐ **Diet - Clear Liquids** Diet effective now, Post-op, Routine
Diet(s): ○ Clear Liquids
Cultural/Special:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☐ **Diet - No Carb Clear Liquid** Diet effective now, Post-op, Routine
Diet(s): ○ No Carbohydrate Clear Liquid
Cultural/Special:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☐ **Diet - No Carb No Caffeine Clear Liquid** Diet effective now, Post-op, Routine
Diet(s): ○ No Carbohydrate Clear Liquid
Foods to Avoid: ○ Caffeine ○ Coffee
Cultural/Special:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:

☐ **Diet - Heart Healthy** Diet effective now, Post-op, Routine, When extubated and patient did not have abdominal surgery. On PostOp day 2 Start giving 4 oz prune juice with 4 oz of warm water every 8 hours. Hold after first bowel movement.
Diet(s): ○ Heart Healthy
Cultural/Special:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☐ **Prune Juice or Prunes** Until discontinued, Post-op, Routine, Give with breakfast daily starting post op day 2

☐ **Tube feeding** Diet effective now, Post-op, Routine
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:
Tube Feeding Schedule:
Dietitian to manage Tube Feed?

IV Fluids

IV Bolus

○ **sodium chloride 0.9 % bolus 1000 mL** 1000 mL, intravenous, once, 1, Occurrences, Post-op, 30.000 Minutes

○ **lactated ringers bolus 1000 mL** 1000 mL, intravenous, once, 1, Occurrences, Post-op, 30.000 Minutes

IV Fluids

○ **sodium chloride 0.9 % infusion** 75 mL/hr, intravenous, continuous, Post-op

○ **lactated Ringer's infusion** 75 mL/hr, intravenous, continuous, Post-op

○ **dextrose 5 % and sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion** 75 mL/hr, intravenous, continuous, Post-op

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

○ **sodium chloride 0.45 % infusion** 75 mL/hr, intravenous, continuous, Post-op

○ **sodium chloride 0.45 % 1,000 mL with sodium bicarbonate 75 mEq/L infusion** 75 mL/hr, intravenous, continuous, Post-op

○ **sodium chloride 0.9 % with potassium chloride 20 mEq/L infusion** 50 mL/hr, intravenous, continuous, Post-op

Other IV Fluids

☑ **sodium chloride 0.9 % infusion** 3 mL/hr, intravenous, continuous PRN, Post-op, For cardiac output and pressure monitoring
Flush every 8 hours and PRN for catheter patency.

☐ **albumin human 5 % bottle** 5 , intravenous, once, Post-op
Indication:

☐ **albumin human 25 % bottle** 25 , intravenous, Post-op
Indication:

Medications

Pharmacy Consults for Heparin Management

☐ **Pharmacy consult to manage Heparin: LOW Dose protocol(ACS/Stroke/Afib)- withOUT titration boluses** Until discontinued, Post-op, STAT
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

☐ **Pharmacy Consult to Manage Heparin: STANDARD dose protocol (DVT/PE) - with titration boluses** Until discontinued, Post-op, STAT
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

PostOp Antibiotics: For Patients LESS than or EQUAL to 100 kg

◉ **ceFAZolin (ANCEF) IV 1 g** 1 g, intravenous, every 8 hours, 2, Occurrences, Post-op, STAT
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

○ **Post-Op Surgical Prophylaxis - IV Vancomycin and Aztreonam**

☑ **Post-Operative Surgical Prophylaxis - Vancomycin** 15 mg/kg, intravenous, once, 1, Occurrences, Post-op, Routine
Indication: ○ Surgical Prophylaxis
Surgical Prophylaxis: Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Pharmacy to automatically adjust dose based on pre-operative administration and renal function

☑ **Post-Operative Surgical Prophylaxis - aztreonam (AZACTAM) IV** 2 g, intravenous, every 8 hours, 2, Occurrences, Post-op, Routine
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Post-Op Antibiotics: For Patients GREATER than 100 kg

◉ **ceFAZolin (ANCEF) IV 1 g** 1 g, intravenous, every 8 hours, 2, Occurrences, Post-op, STAT
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

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

○ **Post-Op Surgical Prophylaxis - IV Vancomycin and Aztreonam**

☑ **Post-Operative Surgical Prophylaxis - Vancomycin** 15 mg/kg, intravenous, once, 1, Occurrences, Post-op, Routine
Indication: ○ Surgical Prophylaxis
Surgical Prophylaxis: Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.: Pharmacy to automatically adjust dose based on pre-operative administration and renal function

☑ **Post-Operative Surgical Prophylaxis - aztreonam (AZACTAM) IV** 2 g, intravenous, every 8 hours, 2, Occurrences, Post-op, Routine
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Inotropes

☐ **DOPamine IV infusion** titrated, STAT

☐ **epINEPHrine infusion** titrated, STAT

☐ **DOButamine (DOBUTREX) infusion** 2 mcg/kg/min, intravenous, continuous, Post-op, STAT

☐ **milrinone (PRIMACOR) infusion** 0.25 mcg/kg/min, intravenous, continuous, Post-op
Contact provider if arrhythmia occurs.

Pressors

☐ **vasopressin (PITRESSIN) infusion** 0.01 - 0.04 Units/min, intravenous, titrated, Post-op, STAT
Recommendation is to titrate with 0.01 to 0.04 units/min. Titrate by 0.01 units/min within 10 minutes. Notify intensivist if SVR is more than 1200. Notify intensivist when titration requires greater than 0.04 units/min. Wean to off when parameters are satisfied. Discontinue vasopressin order in EPIC when off for 4 hours.

☐ **norEPInephrine (LEVOPHED) infusion** titrated, STAT

☐ **phenylephrine (NEO-SYNEPHRINE) infusion** titrated, STAT

IV infusion - Antihypertensives

☐ **niCARDipine (CARDENE) IV infusion** titrated

☐ **diltiazem (CARDIZEM) infusion** 1 - 15 mg/hr, intravenous, continuous, Post-op

☐ **nitroglycerin infusion** 5 - 200 mcg/min, intravenous, continuous, Post-op

☐ **esmolol (BREVIBLOC) infusion** 50 - 200 mcg/kg/min, intravenous, continuous, Post-op

☐ **labetalol (NORMODYNE) infusion** 1 - 5 mg/min, intravenous, continuous, Post-op

Colchicine

☐ **colchicine tablet** 0.6 mg, oral, 2 times daily, 2, Occurrences, Post-op
For prevention of atrial fibrillation post cardiac surgery. Call provider for diarrhea.

Diuretics

☐ **furosemide (LASIX) injection** 40 mg, intravenous, 3 times daily, S+1

☐ **bumetanide (BUMEX) bolus with infusion**

☑ **bumetanide (BUMEX) injection** 1 mg, intravenous

☑ **bumetanide (BUMEX) infusion** 0.5 mg/hr, intravenous, continuous

Electrolytes

☐

Potassium Level (mEq/L)	Potassium Chloride Dose	Monitoring
3.5 – 3.7	20 mEq PO or IV	8 hours post administration
3.2 – 3.4	60 mEq PO or IV	
LESS THAN 3.2	80 mEq IV ONLY	2 hours post administration

Select CENTRAL or PERIPHERAL line order options based on available access
Patients tolerating oral feeding without symptomatic electrolyte abnormalities should receive oral replacement.

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

○ **For potassium 3.5-3.7 mEq/L**

○ **For potassium level 3.5-3.7 mEq/dL: 20 mEq total dose potassium chloride IV**

☑ **potassium chloride 20 mEq in 100 mL IVPB** 20 mEq, intravenous, once, 1, Occurrences, 60.000 Minutes
Total dose 20 mEq. Recheck potassium level 8 hours after total dose is administered. For Central Line administration ONLY

☑ **Recheck potassium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck potassium level 8 hours after total dose is administered.

○ **For potassium level 3.5-3.7 mEq/dL: 20 mEq total dose potassium chloride IV**

☑ **potassium chloride 10 mEq in 100 mL IVPB** 10 mEq, intravenous, every 1 hour, 2, Occurrences
Total dose 20 mEq. Recheck potassium level 8 hours after total dose is administered. For Peripheral Line administration ONLY
Rate of administration should be adjusted according to patient tolerance.

☑ **Recheck potassium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck potassium level 8 hours after total dose is administered.

○ **For potassium level 3.5-3.7 mEq/dL: 20 mEq total dose potassium chloride Oral**

☑ **potassium chloride (K-DUR) CR tablet** 20 mEq, oral, once, 1, Occurrences
Hold Paramaters:
Total dose 20 mEq. Recheck potassium level 8 hours after total dose is administered.

☑ **Recheck potassium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck potassium level 8 hours after total dose is administered.

○ **For potassium level 3.5-3.7 mEq/dL: 20 mEq total dose potassium chloride packet**

☑ **potassium chloride (KLOR-CON) packet** 20 mEq, oral, once, 1, Occurrences
Hold Paramaters:
Total dose 20 mEq. Recheck potassium level 8 hours after total dose is administered.

☑ **Recheck potassium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck potassium level 8 hours after total dose is administered.

○ **For potassium 3.2-3.4 mEq/L**

○ **For potassium level 3.2-3.4 mEq/dL: 40 mEq total dose potassium chloride IV**

☑ **potassium chloride 20 mEq in 100 mL IVPB** 20 mEq, intravenous, every 1 hour, 2, Occurrences, 60.000 Minutes
Total dose 40 mEq. Recheck potassium level 8 hours after total dose is administered. For Central Line administration ONLY

☑ **Recheck potassium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck potassium level 8 hours after total dose is administered.

○ **For potassium level 3.2-3.4 mEq/dL: 40 mEq total dose potassium chloride IV**

☑ **potassium chloride IV 40 mEq total dose over 4 hours** 10 mEq, intravenous, every 1 hour, 4, Occurrences
Total 40 mEq. Recheck potassium level 8 hours after total dose is administered. For Peripheral Line administration ONLY
Rate of administration should be adjusted according to patient tolerance.

☑ **Recheck potassium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck potassium level 8 hours after total dose is administered.

○ **For potassium level 3.2-3.4 mEq/dL: 40 mEq total dose potassium chloride Oral**

☑ **potassium chloride (K-DUR) CR tablet** 40 mEq, oral, once, 1, Occurrences, STAT
Hold Paramaters:
Total dose 40 mEq. Recheck potassium level 8 hours after total dose is administered.

☑ **Recheck potassium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck potassium level 8 hours after total dose is administered.

○ **For potassium level 3.2-3.4 mEq/dL: 40 mEq total dose potassium chloride packet**

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

☑ **potassium chloride (KLOR-CON) packet** 40 mEq, oral, once, 1, Occurrences
Hold Paramaters:
Total dose 40 mEq. Recheck potassium level 8 hours after total dose is administered.

☑ **Recheck potassium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck potassium level 8 hours after total dose is administered.

○ **For potassium level LESS than 3.2 mEq/dL**

○ **For potassium level LESS than 3.2 mEq/dL: 60 mEq total dose potassium chloride IV**

☑ **potassium chloride 20 mEq in 100 mL IVPB** 20 mEq, intravenous, every 1 hour, 3, Occurrences, 60.000 Minutes
Total dose 60 mEq. Recheck potassium level 2 hours after total dose is administered. For Central Line administration ONLY

☑ **Recheck potassium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck potassium level 2 hours after total dose is administered.

○ **For potassium level LESS than 3.2 mEq/dL: 60 mEq total dose potassium chloride IV**

☑ **potassium chloride IV 60 mEq total dose over 6 hours** 10 mEq, intravenous, every 1 hour, 6, Occurrences
Total dose 60 mEq. Recheck potassium level 2 hours after total dose is administered. For Peripheral Line administration ONLY
Rate of administration should be adjusted according to patient tolerance.

☑ **Recheck potassium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck potassium level 2 hours after total dose is administered.

☐

Magnesium Level (mg/dL)	Magnesium Sulfate Dose	Monitoring
2 – 2.3	2 g IV	AM labs
1.5 – 1.9	3 g IV	AM labs
1 – 1.4	4 g IV	2 hours post administration
LESS THAN 1	4 g IV	2 hours post administration AND Contact MD

○ **For magnesium level 2-2.3 mg/dL: 2 gram total dose magnesium sulfate IV**

☑ **magnesium sulfate IV 2 gram total dose** 2 g, intravenous, once, 1, Occurrences
Infusion rate is 2 gm over 2 hours for peripheral or central infusion. Notify MD if magnesium level is less than 1 mg/dL or greater than 4.5 mg/dL Recheck magnesium level in AM.

☑ **Recheck magnesium level** AM draw, 1, Occurrences, Routine, Blood, 3, Recheck magnesium level in AM.

○ **For magnesium level 1.5-1.9 mg/dL: 3 gram total dose magnesium sulfate IV**

☑ **magnesium sulfate IV 3 gram total dose** 3 g, intravenous, once, 1, Occurrences
Infusion rate is 3 gm over 3 hours for peripheral or central infusion. Notify MD if magnesium level is less than 1 mg/dL or greater than 4.5 mg/dL Recheck magnesium level in AM.

☑ **Recheck magnesium level** AM draw, 1, Occurrences, Routine, Blood, 3, Recheck magnesium level in AM.

○ **For magnesium level 1-1.4 mg/dL: 4 gram total dose magnesium sulfate IV**

☑ **magnesium sulfate IV 4 gram total dose** 4 g, intravenous, once, 1, Occurrences, STAT
Infusion rate is 4 gm over 4 hours for peripheral or central infusion.
Notify MD if magnesium level is less than 1 mg/dL or greater than 4.5 mg/dL
Recheck magnesium level 2 hours after total dose is administered.

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

☑ **Recheck magnesium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck magnesium level 2 hours after total dose is administered.

○ **For magnesium LESS THAN 1 mg/dL**

☑ **magnesium sulfate IV 4 gram total dose** 4 g, intravenous, once, 1, Occurrences, STAT
Contact physician immediately for magnesium level LESS than 1 mg/dL
Infusion rate is 4 gm over 4 hours for peripheral or central infusion.

☑ **Notify Physician for magnesium LESS THAN 1 mg/dL** Until discontinued, Routine

☑ **Recheck magnesium level** Once, 1, Occurrences, Routine, Blood, 3, Recheck magnesium level 2 hours after total dose is administered.

☐

Ionized Calcium Level (mg/dL)	Calcium Gluconate IV PERIPHERAL LINE	Calcium Chloride CENTRAL LINE	Monitoring
1.05 – 1.16	3 g IV	1 g IV	8 hours post administration
0.91 – 1.04	3 g IV and Contact provider	2 g IV	
LESS THAN 0.9	Contact provider	3 g IV	

Select CENTRAL or PERIPHERAL line order options based on available access

○ **Calcium chloride or gluconate**

○ **For ionized calcium level 0.91-1.16 mMol/mL: 3 gram total dose calcium gluconate IV**

☑ **calcium gluconate IV** 1 g, intravenous, every 30 min, 3, Occurrences
Total dose 3 gm. Recheck ionized calcium level 8 hours after total dose is administered. For ionized calcium level LESS than 0.91 mMol/mL, contact physician and consider administration of IV calcium replacement using a Central Line.
Administer using a 0.22 micron in-line filter.

☑ **Ionized calcium** Once, 1, Occurrences, Routine, Blood, 3, Recheck ionized calcium level 8 hours after total dose is administered
Deliver specimen immediately to the Core Laboratory.

○ **Calcium chloride IV and lab**

☑ **calcium chloride 1 g in sodium chloride 0.9 % 100 mL IVPB** 1 g, intravenous, once, 1, Occurrences
IRRITANT. Infuse through Central Line only. Total dose 1 gm. Recheck ionized calcium level 8 hours after total dose is administered. Do not infuse in the same IV line as phosphate-containing solutions. Stop the infusion if patient complains of pain or discomfort. Infuse NO faster than 1 gm per hour.

☑ **Ionized calcium** Once, 1, Occurrences, Routine, Blood, 3, Recheck ionized calcium level 8 hours after total dose is administered
Deliver specimen immediately to the Core Laboratory.

○ **For ionized calcium 0.91-1.04 mg/dL**

○ **HM IP CALCIUM GLUCONATE IV, LAB, AND NOTIFY**

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

☑ **calcium gluconate IV** 1 g, intravenous, every 30 min, 3, Occurrences
Total dose 3 gm. Recheck ionized calcium level 8 hours after total dose is administered. For ionized calcium level LESS than 0.91 mMol/mL, contact physician and consider administration of IV calcium replacement using a Central Line.
Administer using a 0.22 micron in-line filter.

☑ **Ionized calcium** Once, 1, Occurrences, Routine, Blood, 3, Recheck ionized calcium level 8 hours after total dose is administered
Deliver specimen immediately to the Core Laboratory.

☑ **Notify Physician for ionized calcium 0.91-1.04mg/dL** Until discontinued, Routine

○ **Calcium chloride IV and lab**

☑ **calcium chloride 1 g in sodium chloride 0.9 % 100 mL IVPB** 1 g, intravenous, once, 1, Occurrences
IRRITANT. Infuse through Central Line only. Total dose 1 gm. Recheck ionized calcium level 8 hours after total dose is administered. Do not infuse in the same IV line as phosphate-containing solutions. Stop the infusion if patient complains of pain or discomfort. Infuse NO faster than 1 gm per hour.

☑ **Ionized calcium** Once, 1, Occurrences, Routine, Blood, 3, Recheck ionized calcium level 8 hours after total dose is administered
Deliver specimen immediately to the Core Laboratory.

○ **Calcium chloride IV and lab**

☑ **calcium chloride 1 g in sodium chloride 0.9 % 100 mL IVPB** 1 g, intravenous, once, 1, Occurrences
IRRITANT. Infuse through Central Line only. Total dose 1 gm. Recheck ionized calcium level 8 hours after total dose is administered. Do not infuse in the same IV line as phosphate-containing solutions. Stop the infusion if patient complains of pain or discomfort. Infuse NO faster than 1 gm per hour.

☑ **Ionized calcium** Once, 1, Occurrences, Routine, Blood, 3, Recheck ionized calcium level 8 hours after total dose is administered
Deliver specimen immediately to the Core Laboratory.

chlorhexidine (PERIDEX)

☑ **chlorhexidine (PERIDEX) 0.12 % solution** 15 mL, Mouth/Throat, 2 times daily, Post-op
While intubated

☐ **Prophylactic POAF (Post-operative Atrial Fibrillation) Protocol**

☐ **Prophylactic POAF (Post-operative Atrial Fibrillation) Protocol**

Pre-operative Issues for Amiodarone Exclusion Criteria
NYHA class IV heart failure symptoms
Sinus bradycardia (heart rate less than 50 bpm)
PR interval more than 220 ms
2nd and 3rd degree atrioventricular block
Corrected QT interval more than 480 ms
Interstitial pulmonary disease
Decompensated liver disease

☑ **amIODarone (NEXTERONE) 300 mg IV Loading Dose**

☑ **amIODarone in dextrose,iso-osm (NEXTERONE) infusion** 150 mg, intravenous, once, 1, Occurrences, 30.000 Minutes
Bag 1 of 2 - total loading dose = 300 mg
May cause QTc prolongation. Use 0.2 Micron Filter Tubing for administration.

☑ **amIODarone in dextrose,iso-osm (NEXTERONE) infusion** 150 mg, intravenous, once, 1, Occurrences, 30.000 Minutes
Bag 2 of 2 - total loading dose = 300 mg
May cause QTc prolongation. Use 0.2 Micron Filter Tubing for administration.

☑ **amIODarone (PACERONE) tablet** 400 mg, oral, 2 times daily, 10, Occurrences, S+1
May cause QTc prolongation.

CABG/VALVE

☐ **aspirin tablet** 325 mg, oral, daily, Post-op
Give WITHIN 6 hours postop.

☐ **aspirin suppository** 300 mg, rectal, once, 1, Occurrences, S, Post-op
Give WITHIN 6 hours postop.

Beta Blockers

○ **metoprolol tartrate (LOPRESSOR) tablet** 25 mg, oral, 2 times daily, S+1, Post-op
BP & HR HOLD parameters for this order: ○ BP & HR HOLD Parameters requested
Contact Physician if:
DO NOT administer if patient is on inotrope, vasopressor, has pacemaker

○ **carvediloL (COREG) tablet** 3.125 , oral, 2 times daily, S+1, Post-op
BP & HR HOLD parameters for this order: ○ BP & HR HOLD Parameters requested
Contact Physician if:
DO NOT administer if heart rate is less than 60; systolic blood pressure is less than 110; patient is on inotrope, vasopressor, has pacemaker

☐ **Sedation**

☐ **propofol (DIPRIVAN) infusion** 0 - 50 mcg/kg/min, intravenous, continuous
LESS than desired sedation effect: Other
Specify: INCREASE rate by 5 mcg/kg/min.
DESIRED sedation effect: Continue the same rate. Reassess sedation within 4 hours.
GREATER than desired sedation effect: DECREASE rate 5 mcg/kg/min while titrating sedation to meet RASS goal, Reassess RASS every 30 minutes
If patient requiring GREATER than: 50 mcg/kg/min, Contact MD to re-evaluate sedation therapy
Propofol continuous infusion is to be used only in intubated patients on mechanical ventilation. Is the patient intubated or pending intubation?
Initiate propofol at 10 mcg/kg/min. After initiation reassess RASS/BIS within 10 min. Titrate for Sedation. No bolus doses unless instructed by provider. A separate "propofol bolus from bottle" order must be placed.

☐ **dexMEDEtomidine (PREcedex) infusion** 0.1 - 1.5 mcg/kg/hr, intravenous, continuous
LESS than desired sedation effect: INCREASE rate by 0.1 mcg/kg/hour. Reassess RASS within 1 hour.
DESIRED sedation effect: Continue the same rate. Reassess sedation within 4 hours
GREATER than desired sedation effect: DECREASE rate by 0.1 mcg/kg/hour. Reassess RASS within one hour.
If patient requiring GREATER than: 1.5 mcg/kg/hr, Contact MD to re-evaluate sedation therapy
Generally for mild to moderate sedation. Not for use in patients on neuromuscular blocking agents. NO LOADING DOSE. After initiation reassess RASS within 1 hour. Titrate DOSE for Sedation.

Postop Anemia

☐ **ferric gluconate (FERRLECIT) injection** 125 mg, intravenous, every 24 hours, 4, Occurrences, Post-op
Indication:

☐ **ferrous sulfate tablet** 325 mg, oral, 2 times daily with meals, Post-op
Each 325 mg tablet contains 65 mg of elemental iron

Statin

☐ **atorvastatin (LIPITOR) tablet** 80 mg, oral, nightly

☐ **simvastatin (ZOCOR) tablet** 20 mg, oral, nightly
If patient is on amiodarone, maximum dose is 10 mg.

☐ **pravastatin (PRAVACHOL) tablet** 40 mg, oral, nightly

☐ **atorvastatin (LIPITOR) tablet** 40 mg, oral, nightly

ACE Inhibitors

○ **captopriL (CAPOTEN) tablet** 25 mg, oral, 3 times daily, Post-op
BP HOLD parameters for this order: ○ BP Hold Parameters requested
Contact Physician if:
Consult MD before administering if urine output less than 5 mL/kg/hour and creatinine greater than 1.3.

○ **enalapril (VASOTEC) tablet** 2.5 mg, oral, 2 times daily, Post-op
BP HOLD parameters for this order: ○ BP Hold Parameters requested
Contact Physician if:
Consult MD before administering if urine output less than 5 mL/kg/hour and creatinine greater than 1.3.

○ **lisinopriL (PRINIVIL) tablet** 5 mg, oral, daily, Post-op
BP HOLD parameters for this order: ○ BP Hold Parameters requested
Contact Physician if:
Consult MD before administering if urine output less than 5 mL/kg/hour and creatinine greater than 1.3.

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

Antiplatelet Agents

○ **Loading Dose Followed By Maintenance**

○ **clopidogrel (PLAVIX) 300 mg Loading Dose followed by 75 mg Maintenance Dose and aspirin EC 81 mg tablet**

☑ **clopidogrel (PLAVIX) 300 mg Loading Dose followed by 75 mg Maintenance Dose and aspirin EC 81 mg tablet**

☑ **clopidogrel (PLAVIX) Loading and Maintenance doses**

☑ **Loading Dose - clopidogrel (PLAVIX) tablet** 300 mg, oral, once, 1, Occurrences, Post-op Loading Dose

☑ **Maintenance Dose - clopidogrel (PLAVIX) tablet** 75 mg, oral, daily, S+1, Post-op Maintenance Dose

○ **ticagrelor (BRILINTA) 180 mg Loading Dose followed by 90 mg Maintenance Dose and aspirin EC 81 mg tablet**

☑ **ticagrelor (BRILANTA) Oral Loading and Maintenance Doses**

☑ **ticagrelor (BRILINTA) tablet** 180 mg, oral, once, 1, Occurrences, Pre-op
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?

☑ **ticagrelor (BRILINTA) tablet** 90 mg, oral, 2 times daily, Pre-op
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?

☑ **aspirin (ECOTRIN) enteric coated tablet** 81 mg, oral, daily, S+1, Post-op

○ **prasugrel (EFFIENT) 60 mg Loading Dose followed by 10 mg Maintenance Dose and aspirin EC 81 mg tablet** (Required)

☑ **prasugrel (EFFIENT) Loading and Maintenance Doses**

Maintenance Dose Instructions:
Lower the dose to 5 mg for high risk patients (age GREATER than or EQUAL to 75 OR weight LESS than 60 kg)

☑ **prasugrel (EFFIENT) tablet** 60 mg, oral, once, 1, Occurrences, Pre-op
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?

☑ **prasugrel (EFFIENT) tablet** 10 mg, oral, daily, Pre-op
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?

☑ **aspirin chewable tablet** 81 mg, oral, once, 1, Occurrences, S+1, Post-op

☑ **Pharmacy Consult to educate patient on prasugrel (EFFIENT)** (Required)

☑ **Pharmacy Consult to educate patient on prasugrel (EFFIENT)** Once, 1, Occurrences, STAT
Which drug do you need help dosing? ○ prasugrel (EFFIENT)
Contact Number:

○ **Maintenance Doses Only**

○ **clopidogrel (PLAVIX) 75 mg Maintenance Dose and aspirin EC 81 mg tablet - Start Tomorrow**

☑ **clopidogrel (PLAVIX) tablet** 75 mg, oral, daily, S+1, Post-op

☑ **aspirin (ECOTRIN) enteric coated tablet** 81 mg, oral, daily, S+1, Post-op

○ **ticagrelor (BRILINTA) 90 mg Maintenance Dose and aspirin EC 81 mg tablet - Start 12 Hours from Now**

☑ **ticagrelor (BRILINTA) tablet** 90 mg, oral, 2 times daily, Post-op
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?

☑ **aspirin (ECOTRIN) enteric coated tablet** 81 mg, oral, daily, S+1, Post-op

○ **prasugrel (EFFIENT) 10 mg Maintenance Dose and aspirin EC 81 mg tablet - Start Tomorrow**

☑ **prasugrel (EFFIENT) tablet** (Required)

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

☑ **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?

☑ **aspirin (ECOTRIN) enteric coated tablet** 81 mg, oral, daily, S+1, Post-op

○ **Anti-Platelet Contraindication** Until discontinued, Post-op, Routine
Reason for "No" order:

Reversal Agents

☐ **Reversal Agents**

☑ **neostigmine methylsulfate (BLOXIVERZ) intravenous solution** 5 mg, intravenous, once PRN, 1, Occurrences, Post-op, reversal of neuromuscular blockade
Leave at bedside. To be administered by a provider.

☑ **glycopyrrolate (ROBINUL) injection** 1 mg, intravenous, once PRN, 1, Occurrences, Post-op, To be given with neostigmine for bradycardia.
To be administered by a provider.

Respiratory Medications

☐ **Scheduled - albuterol (PROVENTIL) nebulizer solution** 2.5 mg, nebulization, Respiratory Therapy - every 6 hours, Post-op
Aerosol Delivery Device: ○ Hand-Held Nebulizer

☐ **PRN - albuterol (PROVENTIL) nebulizer solution** 2.5 mg, nebulization, every 6 hours PRN, Post-op, wheezing
Aerosol Delivery Device: ○ Hand-Held Nebulizer

☐ **Scheduled - ipratropium (ATROVENT) 0.02 % nebulizer solution** 0.5 mg, nebulization, Respiratory Therapy - every 6 hours, Post-op
Aerosol Delivery Device: ○ Hand-Held Nebulizer

☐ **PRN - ipratropium (ATROVENT) 0.02 % nebulizer solution** 0.5 mg, nebulization, every 6 hours PRN, Post-op, wheezing
Aerosol Delivery Device: ○ Hand-Held Nebulizer

☐ **Pain Medications**

Check Prescription Drug Monitoring Program.
Prior to initiation of opioid therapy, it is recommended to check the prescription monitoring program (PMP) database to assess patient's opioid tolerance status. A summarized version of the PMP report may be accessed by clicking on the NaRx Score on the patient's Storyboard. You may access the full version of the Texas PMP here." (https://texas.pmpaware.net/login)
Texas PMP

Due to risk of accumulation of toxic metabolite, the use of morphine in patients with renal dysfunction is not recommended. An alternative opioid should be utilized, if possible.

☐ **Scheduled Pain Medications**
Consider scheduled option if pain source is present and patient unable to reliably communicate needs.
Do not order both scheduled and PRN NSAIDs/APAP simultaneously.

○ **acetaminophen (TYLENOL) 500 mg tablet or liquid**
◉ **acetaminophen (TYLENOL) tablet** 500 mg, oral, every 6 hours scheduled
◉ **acetaminophen (TYLENOL) liquid** 500 mg, oral, every 6 hours scheduled

○ **acetaminophen (TYLENOL) 650 mg tablet or liquid**
◉ **acetaminophen (TYLENOL) tablet** 650 mg, oral, every 6 hours scheduled
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).
◉ **acetaminophen (TYLENOL) liquid** 650 mg, oral, every 6 hours scheduled

○ **NSAIDS: For Patients LESS than 65 years old**
○ **ibuprofen (ADVIL, MOTRIN) tablet or oral suspension**

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

◉ **ibuprofen (ADVIL, MOTRIN) tablet** 600 mg, oral, every 6 hours PRN
Give if patient is able to tolerate oral medication.
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

◉ **ibuprofen (MOTRIN) 100 mg/5 mL suspension** 600 mg, oral, every 6 hours PRN
Use if patient cannot swallow tablet.
Not indicated for infants under 6 months of age. Not recommended in patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet** 250 mg, oral, 2 times daily
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **celecoxib (CeleBREX) capsule** 100 mg, oral, 2 times daily
For age LESS than 65 yo and patients GREATER than 50kg. 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.

○ **ketorolac (TORADOL) injection** 30 mg, intravenous, every 6 hours scheduled, 5, Days
For patients LESS THAN 65 years old. Not recommended for patients with eGFR LESS than 30 mL/min or acute kidney injury.

○ **NSAIDS: For Patients GREATER than or EQUAL to 65 years old**

○ **ibuprofen (ADVIL, MOTRIN) tablet or oral suspension**

◉ **ibuprofen (ADVIL, MOTRIN) tablet** 600 mg, oral, every 6 hours PRN
Give if patient is able to tolerate oral medication.
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

◉ **ibuprofen (MOTRIN) 100 mg/5 mL suspension** 600 mg, oral, every 6 hours PRN
Use if patient cannot swallow tablet.
Not indicated for infants under 6 months of age. Not recommended in patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet** 250 mg, oral, 2 times daily
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **celecoxib (CeleBREX) capsule** 100 mg, oral, 2 times daily
For age GREATER than or EQUAL to 65 yo and patients LESS than 50kg. 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.

○ **ketorolac (TORADOL) injection** 15 mg, intravenous, every 6 hours scheduled, 5, Days

☐ **PRN Pain Medications**

Consider scheduled option if pain source is present and patient unable to reliably communicate needs. Monitor closely for response. Adjust dose for renal/liver function and age. Do not order both scheduled and PRN NSAIDs/APAP simultaneously. Order ONLY one short acting PO and short acting IV simultaneously. Oral option and IV options to be ordered simultaneously.

☐ **PRN Medications for Mild Pain (Pain Score 1-3): For Patients LESS than 65 years old**

Do not order both scheduled and PRN NSAIDs/APAP simultaneously.

○ **aminophen (TYLENOL) tablet OR oral suspension OR rectal suppository**

Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **acetaminophen (TYLENOL) tablet** 650 mg, oral, every 6 hours PRN, mild pain (score 1-3)
Give if patient able to swallow tablet.
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL)suspension** 650 mg, oral, every 6 hours PRN, mild pain (score 1-3)
Use if patient cannot tolerate oral tablet.

◉ **acetaminophen (TYLENOL) suppository** 650 mg, rectal, every 6 hours PRN, mild pain (score 1-3)
Use if patient cannot tolerate oral tablet OR oral solution.
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

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

○ **ibuprofen (ADVIL, MOTRIN) tablet or oral suspension**

◉ **ibuprofen (ADVIL, MOTRIN) tablet** 600 mg, oral, every 6 hours PRN
Give if patient is able to tolerate oral medication.
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

◉ **ibuprofen (MOTRIN) 100 mg/5 mL suspension** 600 mg, oral, every 6 hours PRN
Use if patient cannot swallow tablet.
Not indicated for infants under 6 months of age. Not recommended in patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet** 250 mg, oral, every 8 hours PRN, mild pain (score 1-3)
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **celecoxib (CeleBREX) capsule** 100 mg, oral, 2 times daily PRN, mild pain (score 1-3)
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ketorolac (TORADOL) injection** 15 mg, intravenous, every 6 hours PRN, mild pain (score 1-3)
Give if patient unable to swallow tablet.

☐ **PRN Oral Medications for Mild Pain (Pain Score 1-3): For Patients GREATER than or EQUAL to 65 years old**
Consider scheduled option if pain source is present and patient unable to reliably communicate needs. Monitor closely for response. Adjust dose for renal/liver function and age. Do not order both scheduled and PRN NSAIDs/APAP simultaneously. Order ONLY one short acting PO and short acting IV simultaneously. Oral option and IV options to be ordered simultaneously.

○ **acetaminophen (TYLENOL) tablet OR oral suspension**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **acetaminophen (TYLENOL) tablet** 650 mg, oral, every 6 hours PRN, mild pain (score 1-3)
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL)suspension** 650 mg, oral, every 6 hours PRN, mild pain (score 1-3)
Use if patient cannot tolerate oral tablet.

☐ **PRN Oral Medications for Moderate Pain (Pain Score 4-6): For Patients LESS than 65 years old**

○ **acetaminophen-codeine (TYLENOL #3) tablet OR elixir**

◉ **acetaminophen-codeine (TYLENOL WITH CODEINE #3) 300-30 mg per tablet** 1 tablet, oral, every 6 hours PRN
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources). Give if patient is able to tolerate oral medication.

◉ **acetaminophen-codeine 300 mg-30 mg /12.5 mL solution** 12.5 mL, oral, every 6 hours PRN
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources) Use if patient cannot swallow tablet.

○ **HYDROcodone-acetaminophen 5/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet** 1 tablet, oral, every 6 hours PRN
Allowance for Patient Preference:
Give if patient able to swallow tablet.
Give if patient can receive oral tablet/capsule.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution** 10 mL, oral, every 6 hours PRN
Allowance for Patient Preference:
Give if patient unable to swallow tablet.

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

○ **oxyCODONE (ROXICODONE) immediate release tablet** 5 mg, oral, every 6 hours PRN, moderate pain (score 4-6)
Allowance for Patient Preference:
Tablets may be crushed. Give if patient able to swallow tablet
Give if patient can receive oral tablet/capsule.

○ **traMADoL (ULTRAM) tablet** 50 mg, oral, every 6 hours PRN
Allowance for Patient Preference:
Max daily dose 200 mg/day in patients with CrCl < 30 ml/min. Give if patient able to swallow tablet.
Give if patient can receive oral tablet/capsule.

☐ **PRN Oral Medications for Moderate Pain (Pain Score 4-6): For Patients GREATER than or EQUAL to 65 years old**

○ **acetaminophen-codeine (TYLENOL #3) tablet OR elixir**

◉ **acetaminophen-codeine (TYLENOL WITH CODEINE #3) 300-30 mg per tablet** 1 tablet, oral, every 6 hours PRN
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources). Give if patient is able to tolerate oral medication.

◉ **acetaminophen-codeine 300 mg-30 mg /12.5 mL solution** 12.5 mL, oral, every 6 hours PRN
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources) Use if patient cannot swallow tablet.

○ **HYDROcodone-acetaminophen 5/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet** 1 tablet, oral, every 6 hours PRN
Allowance for Patient Preference:
Give if patient able to swallow tablet.
Give if patient can receive oral tablet/capsule.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution** 10 mL, oral, every 6 hours PRN
Allowance for Patient Preference:
Give if patient unable to swallow tablet.

○ **oxyCODONE (ROXICODONE) immediate release tablet** 2.5 mg, oral, every 6 hours PRN, moderate pain (score 4-6)
Allowance for Patient Preference:
Tablets may be crushed. Give if patient able to swallow tablet
Give if patient can receive oral tablet/capsule.

○ **traMADoL (ULTRAM) tablet** 25 mg, oral, every 6 hours PRN, moderate pain (score 4-6)
Allowance for Patient Preference:
Max daily dose 300mg in patients age GREATER THAN 75 years or 200 mg/day in patients with CrCl < 30 ml/min.
Give if patient able to swallow tablet.
Give if patient can receive oral tablet/capsule.

☐ **PRN IV Medications for Moderate Pain (Pain Score 4-6): For Patients LESS than 65 years old if unable to tolerate Oral Pain Medication.**

Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized.

○ **morPHINE injection** 2 mg, intravenous, every 4 hours PRN, moderate pain (score 4-6)
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications.

○ **hydromorPHONE (DILAUDID) injection** 0.25 mg, intravenous, every 4 hours PRN, moderate pain (score 4-6)
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications

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

○ **ketorolac (TORADOL) IV**

Do NOT use in patients with eGFR LESS than 30 mL/min.
WARNING: Use is contraindicated for treatment of perioperative pain OR in the setting of coronary artery bypass graft (CABG) surgery.

◉ **For patients ages 17-64 AND weight GREATER than or EQUAL to 50 kg AND eGFR at least 60 mL/min - ketorolac (TORADOL) injection** 30 mg, intravenous, every 6 hours PRN, 5, Days, moderate pain (score 4-6)
Use if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications

☐ **PRN IV Medications for Moderate Pain (Pain Score 4-6): For Patients GREATER than or EQUAL to 65 years old if unable to tolerate Oral Pain Medication.**

Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized. (adjust dose for renal/liver function and age)

○ **morPHINE injection** 1 mg, intravenous, every 4 hours PRN, moderate pain (score 4-6)
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications.

○ **hydromorPHONE (DILAUDID) injection** 0.25 mg, intravenous, every 4 hours PRN, moderate pain (score 4-6)
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications

☐ **PRN Oral Medications for Severe Pain (Pain Score 7-10): For Patients LESS than 65 years old**

Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized.

○ **HYDROcodone-acetaminophen 10/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 10-325 mg per tablet** 1 tablet, oral, every 6 hours PRN
Allowance for Patient Preference:
Give if patient able to swallow tablet.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution** 20 mL, oral, every 6 hours PRN
Allowance for Patient Preference:
Give if patient unable to swallow tablet.

○ **morPHINE immediate-release tablet** 15 mg, oral, every 6 hours PRN, severe pain (score 7-10)
Allowance for Patient Preference:
Tablets may be crushed. Give if patient able to swallow tablet
Give if patient can receive oral tablet/capsule.

○ **oxyCODONE (ROXICODONE) immediate release tablet** 10 mg, oral, every 6 hours PRN, severe pain (score 7-10)
Allowance for Patient Preference:
Tablets may be crushed. Give if patient able to swallow tablet
Give if patient can receive oral tablet/capsule.

☐ **PRN Oral Medications for Severe Pain (Pain Score 7-10): For Patients GREATER than or EQUAL to 65 years old**

Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized.

○ **oxyCODONE (ROXICODONE) immediate release tablet** 5 mg, oral, every 6 hours PRN, severe pain (score 7-10)
Allowance for Patient Preference:
Oral tablets may be crushed. Give if patient able to swallow tablet
Give if patient can receive oral tablet/capsule.

○ **morPHINE immediate-release tablet** 7.5 mg, oral, every 6 hours PRN, severe pain (score 7-10)
Allowance for Patient Preference:
Oral tablets may be crushed. Give if patient able to swallow tablets.
Give if patient can receive oral tablet/capsule.

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

○ **HYDROcodone-acetaminophen 7.5/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 7.5-325 mg per tablet** 1 tablet, oral, every 6 hours PRN
Allowance for Patient Preference:
Give if patient able to swallow tablet.
Give if patient can receive oral tablet/capsule.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution** 10 mL, oral, every 6 hours PRN
Allowance for Patient Preference:
Give if patient unable to swallow tablet.

○ **HYDROcodone-acetaminophen 10/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 10-325 mg per tablet** 1 tablet, oral, every 6 hours PRN
Allowance for Patient Preference:
Give if patient able to swallow tablet.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution** 20 mL, oral, every 6 hours PRN
Allowance for Patient Preference:
Give if patient unable to swallow tablet.

○ **traMADoL (ULTRAM) tablet** 50 mg, oral, every 6 hours PRN, severe pain (score 7-10)
Allowance for Patient Preference:
Max daily dose 300mg in patients age GREATER THAN 75 years or 200 mg/day in patients with CrCl < 30 ml/min.
Give if patient able to swallow tablet.
Give if patient can receive oral tablet/capsule.

☐ **PRN IV Medications for Severe Pain (Pain Score 7-10): For Patients LESS than 65 years old if unable to tolerate Oral Pain Medication.**
Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized.

○ **fentaNYL (SUBLIMAZE) injection** 25 mcg, intravenous, every 3 hours PRN, severe pain (score 7-10)
Give if patient is NPO, unable to swallow oral medication, or if pain 60 minutes after giving oral pain medications.

○ **morPHINE injection** 4 mg, intravenous, every 4 hours PRN, severe pain (score 7-10)
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications.

○ **hydromorPHONE (DILAUDID) injection** 0.5 mg, intravenous, every 4 hours PRN, severe pain (score 7-10)
Give if patient is NPO, unable to swallow oral medication, or if pain 60 minutes after giving oral pain medications.

☐ **PRN IV Medications for Severe Pain (Pain Score 7-10): For Patients GREATER than or EQUAL to 65 years old if unable to tolerate Oral Pain Medication.**
Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized.

○ **fentaNYL (SUBLIMAZE) injection** 12.5 mcg, intravenous, every 3 hours PRN, severe pain (score 7-10)
Give if patient is NPO, unable to swallow oral medication, or if pain 60 minutes after giving oral pain medications.

○ **morPHINE injection** 2 mg, intravenous, every 4 hours PRN, severe pain (score 7-10)
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications.

○ **hydromorPHONE (DILAUDID) injection** 0.25 mg, intravenous, every 4 hours PRN, severe pain (score 7-10)
Give if patient is NPO, unable to swallow oral medication, or if pain 60 minutes after giving oral pain medications.

Antiemetics

☐ **ondansetron (ZOFRAN) IV or Oral** (Required)

◉ **ondansetron ODT (ZOFRAN-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.

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

◉ **ondansetron (ZOFRAN) 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 (ZOFRAN) 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 (ZOFRAN) 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 (ZOFRAN) 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 (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

PUD Prophylaxis

◉ **Pantoprazole (PROTONIX) Oral or IV 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
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
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

○ **famotidine (PEPCID) injection** 20 mg, intravenous, 2 times daily, Post-op
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

Bowel Care

☑ **Scheduled: polyethylene glycol (MIRALAX) packet** 17 g, oral, daily, Post-op
Mix in 4-8oz of water.

☐ **As Needed: polyethylene glycol (MIRALAX) packet** 17 g, oral, daily PRN, Post-op, constipation
RN may use second option based on the patient response to the first option attempted.
Mix in 4-8oz of water.

☑ **Docusate - Oral OR Nasogastric**

◉ **docusate sodium (COLACE) capsule** 100 mg, oral, 2 times daily, Post-op

◉ **docusate (COLACE) 50 mg/5 mL liquid** 100 mg, oral, 2 times daily, Post-op

☐ **Docusate - Oral OR Nasogastric**

◉ **docusate sodium (COLACE) capsule** 100 mg, oral, 2 times daily, Post-op

◉ **docusate (COLACE) 50 mg/5 mL liquid** 100 mg, oral, 2 times daily, Post-op

☐ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per tablet** 1 tablet, oral, 2 times daily PRN, Post-op, constipation
AS NEEDED AFTER FIRST BM

☑ **bisacodyl (DULCOLAX) suppository** 10 mg, rectal, daily PRN, Post-op, constipation
FOR RECTAL USE ONLY. AS NEEDED TO MAINTAIN 3 BOWEL MOVEMENTS PER WEEK. DO NOT GIVE IF DIARRHEA NOTED.
Administer if patient has not had a BM in 24 hours after oral therapy

☐ **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)

○ **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:**_____

- [x] **Moderate risk of VTE** Once, Routine
- [x] **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:
- [x] **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)

- [x] **Moderate risk of VTE** Once, Routine
- [x] **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:
- [x] **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)

- [x] **High risk of VTE** Once, Routine
- [x] **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:
- [x] **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)

- [x] **High risk of VTE** Once, Routine
- [x] **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:
- [x] **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)

- [x] **Low Risk** (Required)
  - ◉ **Low risk of VTE** Once, Routine
    Low risk: ○ Due to low risk, no VTE prophylaxis is needed. Will encourgae early ambulation ○ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

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

- [x] **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, PACU & Post-op
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 ≥ 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 ≥ 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, PACU & Post-op, 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, PACU & Post-op
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 ≥ 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 ≥ 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, PACU & Post-op

○ **aspirin (ECOTRIN) enteric coated tablet** 162 mg, daily, S+1, PACU & Post-op

○ **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, PACU & Post-op
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 ≥ 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

○ **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)

○ **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:**_____

- [x] **Moderate risk of VTE** Once, Routine
- [x] **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:
- [x] **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)

- [x] **Moderate risk of VTE** Once, Routine
- [x] **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:
- [x] **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)

- [x] **High risk of VTE** Once, Routine
- [x] **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:
- [x] **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)

- [x] **High risk of VTE** Once, Routine
- [x] **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:
- [x] **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)

- [x] **Low Risk** (Required)
  - ◉ **Low risk of VTE** Once, Routine
    Low risk: ○ Due to low risk, no VTE prophylaxis is needed. Will encourgae early ambulation ○ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

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

- [x] **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, PACU & Post-op
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 ≥ 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 ≥ 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, PACU & Post-op, 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, PACU & Post-op
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 ≥ 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 ≥ 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, PACU & Post-op

○ **aspirin (ECOTRIN) enteric coated tablet** 162 mg, daily, S+1, PACU & Post-op

○ **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, PACU & Post-op
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 ≥ 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

○ **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

Labs Today

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

☐ **Lactic acid level - ONE TIME ORDER ONLY** Once, Post-op, Routine, Blood, 3
SEPSIS PATIENTS:

FOR ALL SEPSIS OR SUSPECTED SEPSIS CHANGE FREQUENCY TO: NOW THEN EVERY 3 HOURS FOR 3 OCCURRENCES

☑ **Basic metabolic panel** Once, Post-op, Routine, Blood, 3

☑ **CBC with platelet and differential** Once, Post-op, Routine, Blood, 3

☑ **Magnesium level** Once, Post-op, Routine, Blood, 3

☑ **Phosphorus level** Once, Post-op, Routine, Blood, 3

☐ **Calcium level** Once, Post-op, Routine, Blood, 3

☑ **Ionized calcium** Once, Post-op, Routine, Blood, 3
Deliver specimen immediately to the Core Laboratory.

☑ **Prothrombin time with INR** Once, Post-op, Routine, Blood, 3

☑ **Partial thromboplastin time** Once, Post-op, 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.

☐ **Platelet function P2Y12** Once, Post-op, Routine, Blood, 3
Draw discard blue top first. BTO tube from Lab. Fill to line. Walk to Lab STAT.

☐ **Platelet mapping** Once, Post-op, Routine, Blood, 3
Anticoagulant Therapy:
Diagnosis:
Fax Number (For TEG Graph Result):
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

☐ **NT-proBNP** Once, Post-op, Routine, Blood, 3

☐ **Anti Xa, unfractionated** Once, Post-op, 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.

☐ **Fibrinogen** Once, Post-op, Routine, Blood, 3

☐ **D-dimer** Once, Post-op, Routine, Blood, 3

☐ **Cortisol level, random** Once, Post-op, Routine, Blood, 3

☐ **Type and screen** Once, Post-op, Routine, Blood

☑ **Blood gas, arterial** Once, Post-op, Routine, Blood, 3

Labs Today

☐ **Lactic acid level - ONE TIME ORDER ONLY** Once, Post-op, Routine, Blood, 3
SEPSIS PATIENTS:

FOR ALL SEPSIS OR SUSPECTED SEPSIS CHANGE FREQUENCY TO: NOW THEN EVERY 3 HOURS FOR 3 OCCURRENCES

☑ **Basic metabolic panel** Once, Post-op, Routine, Blood, 3

☑ **CBC with platelet and differential** Once, Post-op, Routine, Blood, 3

☑ **Magnesium level** Once, Post-op, Routine, Blood, 3

☑ **Phosphorus level** Once, Post-op, Routine, Blood, 3

☐ **Calcium level** Once, Post-op, Routine, Blood, 3

☑ **Ionized calcium** Once, Post-op, Routine, Blood, 3
Deliver specimen immediately to the Core Laboratory.

☑ **Prothrombin time with INR** Once, Post-op, Routine, Blood, 3

☑ **Partial thromboplastin time** Once, Post-op, 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.

☐ **Platelet function P2Y12** Once, Post-op, Routine, Blood, 3
Draw discard blue top first. BTO tube from Lab. Fill to line. Walk to Lab STAT.

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

- [ ] **Platelet mapping** Once, Post-op, Routine, Blood, 3
Anticoagulant Therapy:
Diagnosis:
Fax Number (For TEG Graph Result):
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.
- [ ] **NT-proBNP** Once, Post-op, Routine, Blood, 3
- [ ] **Anti Xa, unfractionated** Once, Post-op, 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.
- [ ] **Fibrinogen** Once, Post-op, Routine, Blood, 3
- [ ] **D-dimer** Once, Post-op, Routine, Blood, 3
- [ ] **Cortisol level, random** Once, Post-op, Routine, Blood, 3
- [ ] **Type and screen** Once, Post-op, Routine, Blood
- [x] **Blood gas, arterial** Once, Post-op, Routine, Blood, 3

Labs Today

- [ ] **Lactic acid level - ONE TIME ORDER ONLY** Once, Post-op, Routine, Blood, 3
SEPSIS PATIENTS:

FOR ALL SEPSIS OR SUSPECTED SEPSIS CHANGE FREQUENCY TO: NOW THEN EVERY 3 HOURS FOR 3 OCCURRENCES
- [x] **Basic metabolic panel** Once, Post-op, Routine, Blood, 3
- [x] **CBC with platelet and differential** Once, Post-op, Routine, Blood, 3
- [x] **Magnesium level** Once, Post-op, Routine, Blood, 3
- [x] **Phosphorus level** Once, Post-op, Routine, Blood, 3
- [ ] **Calcium level** Once, Post-op, Routine, Blood, 3
- [x] **Ionized calcium** Once, Post-op, Routine, Blood, 3
Deliver specimen immediately to the Core Laboratory.
- [x] **Prothrombin time with INR** Once, Post-op, Routine, Blood, 3
- [x] **Partial thromboplastin time** Once, Post-op, 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.
- [ ] **Platelet function P2Y12** Once, Post-op, Routine, Blood, 3
Draw discard blue top first. BTO tube from Lab. Fill to line. Walk to Lab STAT.
- [ ] **NT-proBNP** Once, Post-op, Routine, Blood, 3
- [ ] **Anti Xa, unfractionated** Once, Post-op, 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.
- [ ] **Fibrinogen** Once, Post-op, Routine, Blood, 3
- [ ] **D-dimer** Once, Post-op, Routine, Blood, 3
- [ ] **Cortisol level, random** Once, Post-op, Routine, Blood, 3
- [ ] **Type and screen** Once, Post-op, Routine, Blood
- [x] **Blood gas, arterial** Once, Post-op, Routine, Blood, 3

Labs in 6 Hours

- [ ] **Lactic acid level - ONE TIME ORDER ONLY** Once, 1, Occurrences, Post-op, Routine, Blood, 3, Draw 6 hours postop
SEPSIS PATIENTS:

FOR ALL SEPSIS OR SUSPECTED SEPSIS CHANGE FREQUENCY TO: NOW THEN EVERY 3 HOURS FOR 3 OCCURRENCES
- [ ] **Basic metabolic panel** Once, 1, Occurrences, Post-op, Routine, Blood, 3, Draw 6 hours postop
- [ ] **CBC with platelet and differential** Once, 1, Occurrences, Post-op, Routine, Blood, 3, Draw 6 hours postop

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

- [ ] **Magnesium level** Once, 1, Occurrences, Post-op, Routine, Blood, 3, Draw 6 hours postop
- [ ] **Phosphorus level** Once, 1, Occurrences, Post-op, Routine, Blood, 3, Draw 6 hours postop
- [ ] **Ionized calcium** Once, 1, Occurrences, Post-op, Routine, Blood, 3, Draw 6 hours postop
  Deliver specimen immediately to the Core Laboratory.
- [ ] **Blood gas, arterial** Once, 1, Occurrences, Post-op, Routine, Blood, 3, Draw 6 hours postop

Labs Every 8 hours x 3

- [ ] **Troponin T** Now then every 8 hours, 3, Occurrences, Post-op, Routine, Blood, 3

DIC Panel

- [ ] **Partial thromboplastin time** Once, Post-op, 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.
- [ ] **Prothrombin time with INR** Once, Post-op, Routine, Blood, 3
- [ ] **Fibrinogen** Once, Post-op, Routine, Blood, 3
- [ ] **D-dimer** Once, Post-op, Routine, Blood, 3

Labs Every AM x 3 Days

- [ ] **CBC hemogram** AM draw repeats, 3, Occurrences, Post-op, Routine, Blood, 3
  CBC only; Does not include a differential
- [ ] **Basic metabolic panel** AM draw repeats, 3, Occurrences, Post-op, Routine, Blood, 3
- [ ] **Magnesium level** AM draw repeats, 3, Occurrences, Post-op, Routine, Blood, 3
- [ ] **Phosphorus level** AM draw repeats, 3, Occurrences, Post-op, Routine, Blood, 3
- [ ] **Ionized calcium** AM draw repeats, 3, Occurrences, Post-op, Routine, Blood, 3
  Deliver specimen immediately to the Core Laboratory.

Cardiology

Cardiology

- [x] **ECG 12 lead - Once** Once, Post-op, Routine, 6, Post operative
  Clinical Indications: ○ Post-Op Surgery
  Interpreting Physician:
- [x] **ECG 12 lead - Daily starting tomorrow** Daily, 3, Occurrences, S+1, Post-op, Routine, 6
  Clinical Indications: ○ Post-Op Surgery
  Interpreting Physician:
- [ ] **Echocardiogram complete w contrast and 3D if needed** 1 time imaging, Post-op, 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

X-Ray

- [x] **Chest 1 Vw Portable** 1 time imaging, Post-op, 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:**_____

☐ **Chest 1 Vw Portable (Daily)** Daily imaging, 3, Occurrences, Post-op, 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(after chest tube removal)** Conditional Frequency, 1, Occurrences, Post-op, Routine, After chest tube removal
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Ultrasound

☐ **PV carotid duplex bilateral** 1 time imaging, Post-op, Routine

Respiratory

Respiratory

☐ **Oxygen therapy** Continuous, Post-op, Routine
Device: ○ Nasal Cannula
Rate in liters per minute: 6 Lpm
Titrate to keep O2 Sat Above: ○ 95% ○ 92%
Device:
Indications for O2 therapy:

☐ **Mechanical ventilation** Continuous, Post-op, Routine
Mechanical Ventilation:
Vent Management Strategies: Adult Respiratory Ventilator Protocol

Consults

For Physician Consult orders use sidebar

Referral to Cardiac Rehab Phase II

☑ **Referral to Cardiac Rehab Phase 2** Once
Patient's Phone Number:
I am referring my patient to outpatient Cardiac Rehabilitation for:
Physicians:
Please attach the following information to the referral, if available. This will assist us with patient care, Insurance reimbursement and patient outcomes.

1. Hospital discharge summary, H&P or office note summarizing patient status.
2. Resting 12 lead EKG.
3. Lipid Profile and other lab reports.
4. Recent graded exercise test (within 3 months).
5. Hearth catheterization report.
6. Echocardiogram report.
7. Current Medication List.

Cardiac Rehabilitation Phase II: is the early outpatient phase of Cardiac Rehabilitation and uses exercise training and lifestyle changes to optimize your physical, psychological and social functioning.

Cardiac Rehabilitation benefits may include:
1. Personalized and monitored exercise program proven to increase life expectancy by five years
2. Nutritional counseling
3. Medication review
4. Reduce fear, anxiety and stress
5. Improve your confidence, well being, stamina and strength so that you can return to your usual activities

Houston Methodist Cardiac Rehabilitation Locations:
1. Houston Methodist DeBakey Heart & Vascular Center, Outpatient Center 16th floor, 6445 Main St., Houston, TX 77030 713.441.5575
2. Houston Methodist Baytown Hospital 4201 Garth Road Plaza 1 Suite 290, Baytown TX 77521 281-420-8878
3. Houston Methodist Clear Lake Hospital, MOB 4, 18123 Upper Bay Dr., Suite 110, Houston, TX 77058 281.523.2121
4. Houston Methodist Continuing Care Hospital 701 S. Fry Rd. Suite 215, Katy, TX 77450 832.522.2273
5. Houston Methodist The Woodlands Hospital 7990 State Highway 242, The Woodlands, TX 77385 936.270.3571
6. Houston Methodist Willowbrook Hospital 13802 Centerfield Drive, Suite 200, Houston, TX 77375 281.737.8742
7. Houston Methodist Sugar Land 16605 SW Freeway, Suite 210, Sugar Land, TX 77479 346.874.2050 Fax: 346.874.2051
8. Houston Methodist Cypress 24518 Northwest Fwy. Medical Office Building 2, Suite 105 Cypress, TX 77429 Phone: 346.356.4444 Fax: 713.799.9635

Referral to Cardiac Rehabilitation Phase II (Required)

Please unselect if patient does not meet requirements for Referral to Cardiac Rehab Phase II and select the order: "The patient will not be referred to cardiac rehab due to:" (a reason is required on this order).

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

◉ **Referral to Cardiac Rehab Phase 2** Once, Scheduling/ADT
Patient's Phone Number:
I am referring my patient to outpatient Cardiac Rehabilitation for:
Physicians:
Please attach the following information to the referral, if available. This will assist us with patient care, Insurance reimbursement and patient outcomes.

1. Hospital discharge summary, H&P or office note summarizing patient status.
2. Resting 12 lead EKG.
3. Lipid Profile and other lab reports.
4. Recent graded exercise test (within 3 months).
5. Hearth catheterization report.
6. Echocardiogram report.
7. Current Medication List.

Cardiac Rehabilitation Phase II: is the early outpatient phase of Cardiac Rehabilitation and uses exercise training and lifestyle changes to optimize your physical, psychological and social functioning.

Cardiac Rehabilitation benefits may include:
1. Personalized and monitored exercise program proven to increase life expectancy by five years
2. Nutritional counseling
3. Medication review
4. Reduce fear, anxiety and stress
5. Improve your confidence, well being, stamina and strength so that you can return to your usual activities

Houston Methodist Cardiac Rehabilitation Locations:
1. Houston Methodist DeBakey Heart & Vascular Center, Outpatient Center 16th floor, 6445 Main St., Houston, TX 77030 713.441.5575
2. Houston Methodist Baytown Hospital 4201 Garth Road Plaza 1 Suite 290, Baytown TX 77521 281-420-8878
3. Houston Methodist Clear Lake Hospital, MOB 4, 18123 Upper Bay Dr., Suite 110, Houston, TX 77058 281.523.2121
4. Houston Methodist Continuing Care Hospital 701 S. Fry Rd. Suite 215, Katy, TX 77450 832.522.2273
5. Houston Methodist The Woodlands Hospital 7990 State Highway 242, The Woodlands, TX 77385 936.270.3571
6. Houston Methodist Willowbrook Hospital 13802 Centerfield Drive, Suite 200, Houston, TX 77375 281.737.8742
7. Houston Methodist Sugar Land 16605 SW Freeway, Suite 210, Sugar Land, TX 77479 346.874.2050 Fax: 346.874.2051
8. Houston Methodist Cypress 24518 Northwest Fwy. Medical Office Building 2, Suite 105 Cypress, TX 77429 Phone: 346.356.4444 Fax: 713.799.9635

○ **The patient will not be referred to cardiac rehab due to:** Once, Scheduling/ADT, Routine
The patient will not be referred to cardiac rehab due to:

Ancillary Consults

☑ **Consult to Case Management** Once, Post-op, Routine
Consult Reason: ○ Discharge Planning
Reason for Consult?

☑ **Consult to CV Coordinator** Once, Post-op, Routine
Reason for consult: CABG/VALVE Surgery
Reason for Consult?

☐ **Consult to Social Work** Once, Post-op, Routine
Reason for Consult:
Reason for Consult?

☐ **Consult PT eval and treat** Once, Post-op, 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

☐ **Consult to PT Wound Care Eval and Treat** Once, Post-op, Routine
Special Instructions:
Location of Wound?
Reason for PT?

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

☐ **Consult OT eval and treat** Once, Post-op, 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.

☐ **Consult to Nutrition Services** Once, Post-op, Routine
Reason For Consult?
Purpose/Topic:
Reason for Consult?

☐ **Consult to Spiritual Care** Once, Post-op, Routine
Reason for consult?
Reason for Consult?
For requests after hours, call the house operator.

☐ **Consult to Speech Language Pathology** Once, Post-op, Routine
Reason for consult:
Reason for SLP?

☐ **Consult to Wound Ostomy Care nurse** Once, Post-op, 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, Post-op, Routine
Reason for Consult?
Reason for Consult?

Additional Orders

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