Location: _____

Enhanced Recovery After Surgery (ERAS) Orders

☐ **ERAS Multimodal Pain Medications**

Goal of ERAS multimodal pain management is to preemptively manage and control postoperative pain and reduce opioid use. Select a combination of scheduled around the clock non-opioid analgesic medications and use opioid only for moderate to severe breakthrough pain (pain score 4-10)

☐ **acetaminophen (TYLENOL)**

Select IV then switch to oral or enteral as scheduled OR select oral or enteral post-op; Do not exceed 4 gms a day/2 gms for cirrhotic patients.

○ **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 Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL)suspension Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot swallow tablet.

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
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 Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL)suspension Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot swallow tablet.

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

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
Maximum of 3 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 Dose:** 1000 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
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?
Allowance for Patient Preference:
Admin Instructions:
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.
Product Admin Instructions:
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 Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL)suspension Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot swallow tablet.

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
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)

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

◉ **acetaminophen (TYLENOL) tablet Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL)suspension Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot swallow tablet.

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **acetaminophen (OFIRMEV) IV (RESTRICTED) - for patients that cannot tolerate oral/enteral/rectal Dose:** 1000 mg **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 3 Occurrences **Phase of Care:** PACU & Post-op
Question(s):
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?
Allowance for Patient Preference:
Admin Instructions:
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.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

☐ **Nonsteroidal Anti-inflammatory Drug (NSAID)**

Select Ketorolac(TORADOL) IV and one oral NSAID to follow IV dose OR select one oral NSAID unless contraindicated; Do not give to patients with Stage IV - V CKD or AKI; increases risk of GI bleeding

○ **Ketorolac (TORADOL) IV and one oral NSAID to follow IV dose**

☐ **ketorolac (TORADOL) IV**

○ **ketorolac (TORADOL) 15 mg IV Q6H Dose:** 15 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 15 mg IV Q8H Dose:** 15 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

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

○ **ketorolac (TORADOL) 30 mg IV Q6H Dose:** 30 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 30 mg IV Q8H Dose:** 30 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID.

☑ **Celecoxib (CELEBREX) OR Ibuprofen (MOTRIN) OR Naprosyn Sodium (ALEVE) oral/enteral doses**

○ **celecoxib (CeleBREX) 200 mg Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Do not administer if CrCl < 30 mL/min
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 400 mg Dose:** 400 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 600 mg Dose:** 600 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 800 mg Dose:** 800 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet Dose:** 375 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
DO NOT administer if creatinine > 1 mg/dL and age GREATER than 75 years old
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **Ketorolac (TORADOL) IV and one oral NSAID to follow IV dose**

☐ **ketorolac (TORADOL) IV**

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

○ **ketorolac (TORADOL) 15 mg IV Q6H Dose:** 15 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 15 mg IV Q8H Dose:** 15 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 30 mg IV Q6H Dose:** 30 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 30 mg IV Q8H Dose:** 30 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID.

☑ **Celecoxib (CELEBREX) OR Ibuprofen (MOTRIN) OR Naprosyn Sodium (ALEVE) oral/enteral doses**

○ **celecoxib (CeleBREX) 200 mg Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Do not administer if CrCl < 30 mL/min
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 400 mg Dose:** 400 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 600 mg Dose:** 600 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 800 mg Dose:** 800 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

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

○ **naproxen (NAPROSYN) tablet Dose:** 375 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
DO NOT administer if creatinine > 1 mg/dL and age GREATER than 75 years old
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **Celecoxib (CELEBREX) OR Ibuprofen (MOTRIN) OR Naprosyn Sodium (ALEVE) oral/enteral doses**

○ **celecoxib (CeleBREX) 200 mg Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Do not administer if CrCl < 30 mL/min
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 400 mg Dose:** 400 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 600 mg Dose:** 600 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 800 mg Dose:** 800 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet Dose:** 375 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
DO NOT administer if creatinine > 1 mg/dL and age GREATER than 75 years old
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

☐ **Gabapentinoids**

Consider pregabalin (LYRICA) only if unable to tolerate gabapentin (NEURONTIN)
Contact physician if somnolence or drowsiness persists; Need renal dose adjustment; Do not administer if CrCl < 15 mL/min; Give with caution to patients 65 years of age and older

○ **HM IP MEDICATIONS PREGABALIN ERAS**

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

○ **pregabalin (LYRICA) capsule 25 mg (CrCl greater than or equal to 60 mL/min) Dose:** 25 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **pregabalin (LYRICA) capsule 25 mg (CrCl 30-59 mL/min) Dose:** 25 mg **Route:** oral **Frequency:** 2 times daily **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

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

○ **pregabalin (LYRICA) capsule 25 mg (CrCl 15-29 mL/min)** **Dose:** 25 mg **Route:** oral **Frequency:** at bedtime **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

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

○ **pregabalin (LYRICA) capsule 50 mg (CrCl greater than or equal to 60 mL/min)** **Dose:** 50 mg **Route:** oral **Frequency:** 3 times daily
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **pregabalin (LYRICA) capsule 50 mg (CrCl 30-59 mL/min)** **Dose:** 50 mg **Route:** oral **Frequency:** 2 times daily
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **pregabalin (LYRICA) capsule 50 mg (CrCl 15-29 mL/min)** **Dose:** 50 mg **Route:** oral **Frequency:** at bedtime
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **HM IP GABAPENTIN POSTOP ACUTE ERAS**

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

○ **gabapentin (NEURONTIN) capsule 100 mg (CrCl greater than or equal to 60 mL/min)** **Dose:** 100 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days
Admin Instructions:
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)** **Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily **Frequency Limit:** 5 Days
Admin Instructions:
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)** **Dose:** 100 mg **Route:** oral **Frequency:** at bedtime **Frequency Limit:** 5 Days
Admin Instructions:
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)** **Dose:** 300 mg **Route:** oral **Frequency:** 3 times daily
Admin Instructions:
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)** **Dose:** 300 mg **Route:** oral **Frequency:** 2 times daily
Admin Instructions:
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)** **Dose:** 300 mg **Route:** oral **Frequency:** at bedtime
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

☐ **Muscle Relaxant**

○ **Patients GREATER THAN or EQUAL to 65 years old**

☑ **methocarbamol (ROBAXIN) IV followed by oral**

☑ **methocarbamol (ROBAXIN) IVPB** **Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours scheduled **Frequency Limit:** 3 Occurrences

☑ **methocarbamol (ROBAXIN) tablet** **Dose:** 500 mg **Route:** oral **Frequency:** every 6 hours scheduled **Frequency Limit:** 14 Days

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

☐ **cyclobenzaprine (FLEXERIL) tablet Dose:** 5 mg **Route:** oral **Frequency:** every 12 hours scheduled **Frequency Limit:** 3 Days

○ **Patients LESS THAN 65 years old**

☐ **methocarbamol (ROBAXIN) IV followed by oral**

☑ **methocarbamol (ROBAXIN) IVPB Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours scheduled **Frequency Limit:** 3 Occurrences

☑ **methocarbamol (ROBAXIN) tablet Dose:** 500 mg **Route:** oral **Frequency:** every 6 hours scheduled **Frequency Limit:** 14 Days

☐ **cyclobenzaprine (FLEXERIL) tablet Dose:** 5 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 7 Days

☐ **lidocaine (LIDODERM) patch**

☑ **lidocaine (LIDODERM) 5 % Dose:** 1 patch **Route:** transdermal **Frequency:** every 24 hours
Admin Instructions:
Remove after 12 hours (do not give to patients with adhesive sensitivity or allergies to lidocaine).
Product Admin Instructions:
Apply to affected area. Remove patch 12 hours after applying.

☐ **Opioids**

Only for moderate to severe breakthrough pain

☐ **For moderate breakthrough pain (pain score 4-6)**

☐ **oxyCODone (ROXICODONE) immediate release tablet Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Comment:** moderate pain (Non verbal CPOT or pain score 4-6) **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **traMADoL (ULTRAM)**

○ **traMADoL (ULTRAM) tablet - patients with cirrhosis Dose:** 50 mg **Route:** oral **Frequency:** every 12 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **traMADoL (ULTRAM) tablet Dose:** 50 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **For severe breakthrough pain (pain score 7-10)**

☐ **oxyCODone (ROXICODONE) IR - patients LESS than 65 years old Dose:** 10 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **oxyCODONE (ROXICODONE) IR - patients 65 years old and greater Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

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

☐ **traMADol (ULTRAM) tablet Dose:** 100 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **hydromorPHONE (DILAUDID) injection Dose:** 0.2 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
IF unable to tolerate oral intake

General

Common Present on Admission Diagnosis

☐ **Acidosis Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Acute Post-Hemorrhagic Anemia Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Acute Renal Failure Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Acute Respiratory Failure Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Acute Thromboembolism of Deep Veins of Lower Extremities Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Anemia Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Bacteremia Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Bipolar disorder, unspecified Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Cardiac Arrest Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Cardiac Dysrhythmia Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Cardiogenic Shock Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Decubitus Ulcer Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Dementia in Conditions Classified Elsewhere Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Disorder of Liver Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Electrolyte and Fluid Disorder Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Intestinal Infection due to Clostridium Difficile Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Methicillin Resistant Staphylococcus Aureus Infection Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Obstructive Chronic Bronchitis with Exacerbation Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Other Alteration of Consciousness Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Other and Unspecified Coagulation Defects Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Other Pulmonary Embolism and Infarction Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Phlebitis and Thrombophlebitis Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Protein-calorie Malnutrition Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Psychosis, unspecified psychosis type Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Schizophrenia Disorder Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Sepsis Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Septic Shock Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Septicemia Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Type II or Unspecified Type Diabetes Mellitus with Mention of Complication, Not Stated as Uncontrolled Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Urinary Tract Infection, Site Not Specified Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

Elective Outpatient, Observation, or Admission

○ **Elective outpatient procedure: Discharge following routine recovery Frequency:** Continuous **Phase of Care:** PACU & Post-op **Priority:** Routine

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

◯ **Outpatient observation services under general supervision** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

◯ **Outpatient in a bed - extended recovery** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

◯ **Admit to Inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Level of Care:
Patient Condition:
Bed request comments:
Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

Admission or Observation

Patient has active outpatient status order on file

◯ **Admit to Inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
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** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

◯ **Outpatient in a bed - extended recovery** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

◯ **Transfer patient** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Level of Care:
Bed request comments:

◯ **Return to previous bed** **Frequency:** Until discontinued **Phase of Care:** Scheduling/ADT **Priority:** Routine

Admission

Patient has active status order on file

◯ **Admit to inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
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** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Level of Care:
Bed request comments:

◯ **Return to previous bed** **Frequency:** Until discontinued **Phase of Care:** Scheduling/ADT **Priority:** Routine

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

Transfer

Patient has active inpatient status order on file

○ **Transfer patient** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Level of Care:
Bed request comments:

○ **Return to previous bed** **Frequency:** Until discontinued **Phase of Care:** Scheduling/ADT **Priority:** Routine

Code Status

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

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

○ **Full code** **Frequency:** Continuous **Priority:** Routine
Question(s):
Code Status decision reached by:

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

☑ **DNR (Do Not Resuscitate)** **Frequency:** Continuous **Priority:** Routine
Question(s):
Did the patient/surrogate require the use of an interpreter?
Did the patient/surrogate require the use of an interpreter?
Does patient have decision-making capacity?
I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT Active until Signed by the Responsible Attending Physician.:
Code Status decision reached by:

☐ **Consult to Palliative Care Service**

☑ **Consult to Palliative Care Service** **Frequency:** Once **Priority:** Routine
Question(s):
Priority:
Reason for Consult?
Order?
Name of referring provider:
Enter call back number:
Reason for Consult?
Process Instructions:
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** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult:
Reason for Consult?

○ **Modified Code** **Frequency:** Continuous **Priority:** Routine
Question(s):
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))** **Frequency:** Continuous - Treatment Restrictions **Phase of Care:** Post-op **Priority:** Routine
Question(s):
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:
Process Instructions:
Treatment Restrictions is NOT a Code Status order. It is NOT a Modified Code order. It is strictly intended for Non Cardiopulmonary situations.

The Code Status and Treatment Restrictions are two SEPARATE sets of physician's orders. For further guidance, please click on the link below: Guidance for Code Status & Treatment Restrictions

Examples of Code Status are Full Code, DNR, or Modified Code. An example of a Treatment Restriction is avoidance of blood transfusion in a Jehovah's Witness patient.

If the Legal Surrogate is the Primary Physician, consider ordering a Biomedical Ethics Consult PRIOR to placing this order. A Concurring Physician is required to second sign the order when the Legal Surrogate is the Primary Physician.

Isolation

☐ **Airborne isolation status**

☑ **Airborne isolation status** **Frequency:** Continuous **Priority:** Routine

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

☐ **Contact isolation status** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Droplet isolation status** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Enteric isolation status** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

Precautions

☐ **Aspiration precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Fall precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Increased observation level needed:

☐ **Latex precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Seizure precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Increased observation level needed:

Nursing

Vital Signs

☑ **Vital signs - T/P/R/BP** **Frequency:** Every 15 min **Phase of Care:** Post-op **Priority:** Routine **Comments:** Perform vital signs every 15 minutes x 2 hours, every 30 minutes x 2 hours, and every hour after that.

☐ **Vital signs - T/P/R/BP every hour** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine

Activity/Position

☐ **Strict bed rest** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Head of Bed elevated 45 degrees, bed in flex position at hips.

☐ **Head of bed 45 degrees** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** 45 degrees in breast reconstruction patients
Question(s):
Head of bed: ○ 45 degrees

☐ **Patient position: Semi-Fowler's** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** With bed flexed in semi-fowler's (lawn chair) position
Question(s):
Position: ○ semi-Fowler's
Additional instructions:

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

☐ **Up in chair on postop Day # *** Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** to chair on PostOp Day # ***
Question(s):
Specify: ○ Up in chair

☐ **Up in chair post operative Day #1 Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Post Operative Day #1. Sitting trial in recliner (NOT Cardiac Chair) after seen by the plastics service. Please refer to the Sitting Trial Protocol. If the sitting trial goes well, ie no changes in the doppler signals or flap perfusion, the patient will be ready for transfer to Acute Care Unit
Question(s):
Specify: ○ Up in chair

☐ **Ambulate with assistance Frequency:** 3 times daily **Phase of Care:** Post-op **Priority:** Routine **Comments:** On PostOp Day # *** ambulate in hallway WITH ASSISTANCE after patient has been seen by Plastics. (Do not leave patient alone)
Question(s):
Specify: ○ with assistance ○ in hall

Nursing Care

☐ **Apply warming blanket Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Bair Hugger to flap(s) continuously

☐ **Keep room temp at 76 degrees Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Intake and output Frequency:** Per unit protocol **Phase of Care:** Post-op **Priority:** Routine

☐ **Remove Foley catheter Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Limb precautions Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Location:
Precaution:

☐ **Bathe patient Frequency:** Daily **Phase of Care:** Post-op **Priority:** Routine **Comments:** Sponge bath

☐ **Patient may shower with assistance Frequency:** Daily **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Additional modifier: ○ with assist only
Specify:

☐ **Do NOT use Hyperglycemia Protocol Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Electrolyte replacement per SICU protocol Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Patient education- Post op urine color Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Patient/Family: ○ Both
Education for: ○ Other (specify)
Specify: Blue/green urine post op is normal

Flap/Incision Care

☐ **Apply warming blanket Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Bair Hugger to flap(s) continuously; Discontinue on PostOp Day ***

☐ **Drain care Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Drain 1: ○ Jackson Pratt
Specify location: To bulb suction. Attach bulbs to gown with safety pins. Do NOT tape drains to patient.
Drainage/Suction: To Compression (Bulb) Suction
Drain 2:
Drain 3:
Drain 4:
All Drains:

☐ **Drain care Frequency:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** Strip drain tubing, empty bulb, and record output with all other intake and output values
Question(s):
Drain 1:
Drain 2:
Drain 3:
Drain 4:
All Drains:

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

☐ **Flap assessment** **Frequency:** Every 15 min **Phase of Care:** Post-op **Priority:** Routine **Comments:** Check flap(s) for Doppler sound and color every 15 minutes x 2 hours, every 30 minutes x 4 hours, then every hour after that. Have patient pump feet during each doppler check to prevent DVT. Notify resident or physician of flap changes ASAP.
Question(s):
Location: ○ Breast
Side:

☐ **Flap assessment** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Location: ○ Breast
Side:

☐ **Supportive bra** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Do not remove post operative bra

☐ **Provide equipment / supplies at bedside** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Supplies:

☐ **Provide equipment / supplies at bedside: Extra Bra to bedside** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Size ***
Question(s):
Supplies: ○ Other (specify)
Other: Extra bra to bedside.

☐ **Surgical/incision site care** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Do not remove or change surgical dressings.
Question(s):
Location:
Site:
Apply:
Dressing Type:
Open to air?

☐ **Wound care orders** **Frequency:** Daily **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Location:
Site:
Irrigate wound?
Apply:
Dressing Type:
Process Instructions:
This Nursing Order is NOT for a CONSULT for PT Wound Care or WOC nurse. The order is not transmitted to any department.

Do NOT use this order to request :
Bedside debridement, Ultrasound Therapy, Pulsed Lavage, Negative Pressure Vacuum Therapy, Compression therapy, WOC ongoing wound /ostomy management and teaching.

☐ **Patient education (specify)- Drain care** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Patient/Family: ○ Both
Education for: ○ Drain care

Notify

☐ **Notify Plastic Surgery resident on-call and Plastics Attending Surgeon for ANY questions regarding the flap or change in flap assessment** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Notify Plastic Surgery resident on-call and Plastics Attending Surgeon for ANY questions regarding the flap or change in flap assessment

☐ **Notify Plastics Attending for approval prior to administering vasopressors or diuretic medications** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Notify Physician for any concerns** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

Diet

☐ **NPO** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
NPO:
Pre-Operative fasting options:
Process Instructions:
An NPO order without explicit exceptions means nothing can be given orally to the patient.

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

☐ **NPO except ice chips** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
NPO: ○ Except Ice chips
Pre-Operative fasting options:
Process Instructions:
An NPO order without explicit exceptions means nothing can be given orally to the patient.

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

☐ **Diet- Clear liquids advance as tolerated to Regular** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Diet(s): ○ Clear Liquids
Advance Diet as Tolerated? ○ Yes
Target Diet: Regular
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☐ **Diet- Soft** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Diet(s): ○ GI Soft/Low Residue/Fiber
Foods to Avoid: ○ Caffeine
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:

☐ **Diet: Regular** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Diet(s): ○ Regular
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

IV Fluids

IV Fluids

☐ **dextrose 5 % and sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion** **Dose:** 125 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☐ **lactated Ringer's infusion** **Dose:** 125 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☐ **sodium chloride 0.9 % infusion** **Dose:** 125 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

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

☐ **sodium chloride 0.9 % with potassium chloride 20 mEq/L infusion Dose:** 125 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☐ **sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion Dose:** 125 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

Medications

Reminder: If you need to place orders for PCA Analgesia, after using this order set go to the *Order Set Activity* and access the **General Patient Controlled Analgesia (PCA) Therapy for Opioid Naive Patients** (or Tolerant Patients if appropriate).

Pharmacy Consult

☐ **Pharmacy consult to manage dosing of medication Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Which drug do you need help dosing?
Contact Number:

IV Antibiotics: For Patients LESS than or EQUAL to 120 kg

☐ **ampicillin-sulbactam (UNASYN) IV Dose:** 3 g **Route:** intravenous **Frequency:** every 6 hours **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☐ **cefazolin (ANCEF) IV - For Patients LESS than or EQUAL to 120 kg Dose:** 2 g **Route:** intravenous **Frequency:** every 8 hours **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☐ **cefepime (MAXIPIME) IV - For antipseudomonal coverage Dose:** 1 g **Route:** intravenous **Frequency:** every 8 hours **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
STANDARD Infusion

☐ **clindamycin (CLEOCIN) IV Dose:** 900 mg **Route:** intravenous **Frequency:** every 8 hours **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: Surgical Prophylaxis
Indication:
Admin Instructions:
Use if patient penicillin allergic.

☐ **IV Vancomycin Loading Dose + Pharmacy Consult**

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
Loading Dose

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

IV Antibiotics: For Patients GREATER than 120 kg

☐ **ampicillin-sulbactam (UNASYN) IV Dose:** 3 g **Route:** intravenous **Frequency:** every 6 hours **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☐ **cefazolin (ANCEF) IV - For Patients GREATER than 120 kg Dose:** 3 g **Route:** intravenous **Frequency:** every 8 hours
Phase of Care: Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☐ **cefepime (MAXIPIME) IV - For antipseudomonal coverage Dose:** 2 g **Route:** intravenous **Frequency:** every 8 hours
Phase of Care: Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
STANDARD Infusion

☐ **clindamycin (CLEOCIN) IV Dose:** 900 mg **Route:** intravenous **Frequency:** every 8 hours **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: Surgical Prophylaxis
Indication:
Admin Instructions:
Use if patient penicillin allergic.

☐ **IV Vancomycin Loading Dose + Pharmacy Consult**

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
Loading Dose

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

Oral Antibiotics

☐ **amoxicillin-pot clavulanate (AUGMENTIN) 875-125 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** 2 times daily
Phase of Care: Post-op
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☐ **cephalexin (KEFLEX) capsule Dose:** 500 mg **Route:** oral **Frequency:** every 8 hours **Phase of Care:** Post-op
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☐ **clindamycin (CLEOCIN) capsule Dose:** 450 mg **Route:** oral **Frequency:** 4 times daily **Phase of Care:** Post-op
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Use if patient is penicillin allergic.

☐ **minocycline (MINOCIN,DYNACIN) capsule Dose:** 100 mg **Route:** oral **Frequency:** every 12 hours **Phase of Care:** Post-op
Question(s):
Indication: Surgical Prophylaxis
Indication:
Admin Instructions:
Hold tube feeds for 2 hours pre- and 2 hours post-administration

☐ **sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 12 hours scheduled **Phase of Care:** Post-op
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Topical Antibiotics

☐ **bacitracin ointment Dose:** 500 **Route:** Topical **Frequency:** 3 times daily **Phase of Care:** Post-op
Admin Instructions:
Apply to drain site.

☐ **bacitracin-polymyxin B (POLYSPORIN) ointment Dose:** 500-10000 **Route:** Topical **Frequency:** 3 times daily **Phase of Care:** Post-op
Admin Instructions:
Apply to drain site.

☐ **neomycin-bacitracin-polymyxinB (NEOSPORIN) ointment Dose:** 3.5mg-400 unit- **Route:** Topical **Frequency:** 3 times daily **Phase of Care:** Post-op
Admin Instructions:
Apply to drain site.

☐ **mupirocin (BACTROBAN) 2 % ointment Dose:** 2 **Route:** Topical **Frequency:** 3 times daily **Phase of Care:** Post-op
Admin Instructions:
Apply to drain site.

☐ **povidone-iodine (BETADINE) ointment Dose:** 10 **Route:** Topical **Frequency:** 3 times daily **Phase of Care:** Post-op
Admin Instructions:
Apply to drain site.

Anxiolytics

☐ **LORazepam (ATIVAN) Oral or IV**

◉ **LORazepam (ATIVAN) tablet Dose:** 1 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Comment:** for CIWA score 9-15 **PRN Reasons:** agitation
Question(s):
Indication(s): ○ Withdrawal
Admin Instructions:
Give the tablet if the patient can tolerate oral medication.

◉ **LORazepam (ATIVAN) injection Dose:** 1 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Comment:** for CIWA score 9-15 **PRN Reasons:** agitation
Question(s):
Indication(s): ○ Withdrawal
Admin Instructions:
Give if unable to take oral OR symptoms inadequately controlled on oral medication.

Muscle Spasms

Caution: muscle relaxants should be minimized in patients over 65 years of age.

○ **cyclobenzaprine (FLEXERIL) tablet Dose:** 5 mg **Route:** oral **Frequency:** every 8 hours PRN **Phase of Care:** Post-op **PRN Reasons:** muscle spasms

○ **methocarbamol (ROBAXIN) tablet Dose:** 500 mg **Route:** oral **Frequency:** 3 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** muscle spasms

Muscle Pain

☐ **diazepam (VALIUM) tablet Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Comment:** muscle pain
Question(s):
Indication(s): ○ Other
Specify: Muscle Pain

On-Q Pump

○ **ropivacaine 0.2% (PF) (NAROPIN) solution for On-Q Pump Dose:** 270 mL **Route:** infiltration **Frequency:** continuous **Phase of Care:** Post-op
Question(s):
Continuous Rate: ○ 6 mL/hr
Regional Block:
Location:
Catheter:
Bolus Dose (Optional):
Product Admin Instructions:
This is a disposable, single-use product for Regional Block use. Do NOT refill

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

○ **ropivacaine 0.5% (PF) (NAROPIN) solution for On-Q Pump Dose:** 270 mL **Route:** infiltration **Frequency:** continuous
Phase of Care: Post-op
Question(s):
Continuous Rate: ○ 6 mL/hr
Regional Block:
Location:
Catheter:
Bolus Dose (Optional):
Product Admin Instructions:
This is a disposable, single-use product for Regional Block use. Do NOT refill

PCA Medications - Not HMSJ

○ **fentaNYL PCA (SUBLIMAZE) 1500 mcg/30 mL + Nursing PCA Orders**

☑ **fentaNYL PCA (SUBLIMAZE) 1500 mcg/30 mL**

○ **fentaNYL (SUBLIMAZE) 1500 mcg/30 mL PCA solution for Opioid Naive Dose:** 50 **Route:** intravenous **Frequency:** continuous
Admin Instructions:
For breakthrough pain: Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. RN may bolus *** every *** hours as needed. If pain persists, may increase PCA demand dose by *** mcg ONCE. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber.

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

☑ **Vital signs - T/P/R/BP Frequency:** Per unit protocol **Priority:** Routine **Comments:** - Initially and every 30 minutes for 1 hour after PCA started, bolus administration or dose change; then - Every hour x 2 starting second hour after PCA started, bolus administered or dose change; then - Every 4 hours until PCA therapy is discontinued. - Immediately following PCA administration tubing change

☑ **PCA Documentation Frequency:** Every 12 hours **Priority:** Routine **Comments:** At the beginning (or end of each shift), prior to clearing PCA pump data, the following must be documented: doses delivered, number of attempts, total amount of medication infused (in mg or mcg), and volume remaining in syringe (residual volume).

☑ **Patient education Pain pump Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Comments:** Provide patient education on appropriate use of PCA including no PCA by proxy. Only the patient may press the dosing button.
Question(s):
Education for: ○ Pain pump
Patient/Family:

☑ **Pasero Opioid-induced Sedation Scale Frequency:** Every 6 hours **Start Date:** S **Priority:** Routine **Comments:** Assess POSS while patient has an active PCA order. Contact provider if score 3 or 4.

☑ **Notify Physician Frequency:** Until discontinued **Priority:** Routine **Comments:** - PCA pump infusion discontinued for any reason - Inadequate analgesia - Prior to administration of any other narcotics, antiemetics, or sedatives other than those ordered by the prescriber responsible for IV PCA therapy - PCA pump discontinued by any service other than the prescriber responsible for IV PCA therapy

☑ **Stop the PCA pump and call ordering physician and/or CERT team for any of the following: Frequency:** Until discontinued **Priority:** Routine **Comments:** - Respiratory rate 10 per minute or less - Severe and/or recent confusion or disorientation - POSS sedation level 4: Somnolent and difficult to arouse - Sustained hypotension (SBP less than 90) - Excessive nausea or vomiting - Urinary retention

☑ **IV Fluids for provision of PCA Therapy**

◉ **sodium chloride 0.9 % infusion Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

○ **dextrose 5% infusion Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

○ **hydromorPHONE PCA (DILAUDID) 15 mg/30 mL + Nursing PCA Orders**

☑ **hydromorPHONE PCA (DILAUDID) 15 mg/30 mL**

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

○ **hydromorPHONE (DILAUDID) 15 mg/30 mL in sodium chloride 0.9% PCA for Opioid Naive Dose:** .5 **Route:** intravenous **Frequency:** continuous
Admin Instructions:
For breakthrough pain: Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. RN may bolus *** every *** hours as needed. If pain persists, may increase PCA demand dose by *** mg ONCE. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber.

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

☑ **Vital signs - T/P/R/BP Frequency:** Per unit protocol **Priority:** Routine **Comments:** - Initially and every 30 minutes for 1 hour after PCA started, bolus administration or dose change; then - Every hour x 2 starting second hour after PCA started, bolus administered or dose change; then - Every 4 hours until PCA therapy is discontinued. - Immediately following PCA administration tubing change

☑ **PCA Documentation Frequency:** Every 12 hours **Priority:** Routine **Comments:** At the beginning (or end of each shift), prior to clearing PCA pump data, the following must be documented: doses delivered, number of attempts, total amount of medication infused (in mg or mcg), and volume remaining in syringe (residual volume).

☑ **Patient education Pain pump Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Comments:** Provide patient education on appropriate use of PCA including no PCA by proxy. Only the patient may press the dosing button.
Question(s):
Education for: ○ Pain pump
Patient/Family:

☑ **Pasero Opioid-induced Sedation Scale Frequency:** Every 6 hours **Start Date:** S **Priority:** Routine **Comments:** Assess POSS while patient has an active PCA order. Contact provider if score 3 or 4.

☑ **Notify Physician Frequency:** Until discontinued **Priority:** Routine **Comments:** - PCA pump infusion discontinued for any reason - Inadequate analgesia - Prior to administration of any other narcotics, antiemetics, or sedatives other than those ordered by the prescriber responsible for IV PCA therapy - PCA pump discontinued by any service other than the prescriber responsible for IV PCA therapy

☑ **Stop the PCA pump and call ordering physician and/or CERT team for any of the following: Frequency:** Until discontinued **Priority:** Routine **Comments:** - Respiratory rate 10 per minute or less - Severe and/or recent confusion or disorientation - POSS sedation level 4: Somnolent and difficult to arouse - Sustained hypotension (SBP less than 90) - Excessive nausea or vomiting - Urinary retention

☑ **IV Fluids for provision of PCA Therapy**

◉ **sodium chloride 0.9 % infusion Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

○ **dextrose 5% infusion Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

○ **morPHINE PCA 30 mg/30 mL + Nursing PCA Orders**

☑ **morPHINE PCA 30 mg/30 mL**

○ **morPHINE PCA 30 mg/30 mL in sodium chloride 0.9% for Opioid Naive Dose:** 3 **Route:** intravenous **Frequency:** continuous
Admin Instructions:
For breakthrough pain: Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. RN may bolus *** every *** hours as needed. If pain persists, may increase PCA demand dose by *** mg ONCE. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber.

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

☑ **Vital signs - T/P/R/BP Frequency:** Per unit protocol **Priority:** Routine **Comments:** - Initially and every 30 minutes for 1 hour after PCA started, bolus administration or dose change; then - Every hour x 2 starting second hour after PCA started, bolus administered or dose change; then - Every 4 hours until PCA therapy is discontinued. - Immediately following PCA administration tubing change

☑ **PCA Documentation Frequency:** Every 12 hours **Priority:** Routine **Comments:** At the beginning (or end of each shift), prior to clearing PCA pump data, the following must be documented: doses delivered, number of attempts, total amount of medication infused (in mg or mcg), and volume remaining in syringe (residual volume).

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

☑ **Patient education Pain pump** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Comments:** Provide patient education on appropriate use of PCA including no PCA by proxy. Only the patient may press the dosing button.
Question(s):
Education for: ○ Pain pump
Patient/Family:

☑ **Pasero Opioid-induced Sedation Scale** **Frequency:** Every 6 hours **Start Date:** S **Priority:** Routine **Comments:** Assess POSS while patient has an active PCA order. Contact provider if score 3 or 4.

☑ **Notify Physician** **Frequency:** Until discontinued **Priority:** Routine **Comments:** - PCA pump infusion discontinued for any reason - Inadequate analgesia - Prior to administration of any other narcotics, antiemetics, or sedatives other than those ordered by the prescriber responsible for IV PCA therapy - PCA pump discontinued by any service other than the prescriber responsible for IV PCA therapy

☑ **Stop the PCA pump and call ordering physician and/or CERT team for any of the following:** **Frequency:** Until discontinued **Priority:** Routine **Comments:** - Respiratory rate 10 per minute or less - Severe and/or recent confusion or disorientation - POSS sedation level 4: Somnolent and difficult to arouse - Sustained hypotension (SBP less than 90) - Excessive nausea or vomiting - Urinary retention

☑ **IV Fluids for provision of PCA Therapy**

◉ **sodium chloride 0.9 % infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

○ **dextrose 5% infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

PCA Medications - HMSJ Only

○ **fentaNYL PCA (SUBLIMAZE) 1500 mcg/30 mL + Nursing PCA Orders**

☑ **fentaNYL PCA (SUBLIMAZE) 1500 mcg/30 mL**

○ **fentaNYL (SUBLIMAZE) 1500 mcg/30 mL PCA solution for Opioid Naive** **Dose:** 50 **Route:** intravenous **Frequency:** continuous
Admin Instructions:
For breakthrough pain: Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. RN may bolus *** every *** hours as needed. If pain persists, may increase PCA demand dose by *** mcg ONCE. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber.

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

☑ **Vital signs - T/P/R/BP** **Frequency:** Per unit protocol **Priority:** Routine **Comments:** - Initially and every 30 minutes for 1 hour after PCA started, bolus administration or dose change; then - Every hour x 2 starting second hour after PCA started, bolus administered or dose change; then - Every 4 hours until PCA therapy is discontinued. - Immediately following PCA administration tubing change

☑ **PCA Documentation** **Frequency:** Every 12 hours **Priority:** Routine **Comments:** At the beginning (or end of each shift), prior to clearing PCA pump data, the following must be documented: doses delivered, number of attempts, total amount of medication infused (in mg or mcg), and volume remaining in syringe (residual volume).

☑ **Patient education Pain pump** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Comments:** Provide patient education on appropriate use of PCA including no PCA by proxy. Only the patient may press the dosing button.
Question(s):
Education for: ○ Pain pump
Patient/Family:

☑ **Pasero Opioid-induced Sedation Scale** **Frequency:** Every 6 hours **Start Date:** S **Priority:** Routine **Comments:** Assess POSS while patient has an active PCA order. Contact provider if score 3 or 4.

☑ **Notify Physician** **Frequency:** Until discontinued **Priority:** Routine **Comments:** - PCA pump infusion discontinued for any reason - Inadequate analgesia - Prior to administration of any other narcotics, antiemetics, or sedatives other than those ordered by the prescriber responsible for IV PCA therapy - PCA pump discontinued by any service other than the prescriber responsible for IV PCA therapy

☑ **Stop the PCA pump and call ordering physician and/or CERT team for any of the following:** **Frequency:** Until discontinued **Priority:** Routine **Comments:** - Respiratory rate 10 per minute or less - Severe and/or recent confusion or disorientation - POSS sedation level 4: Somnolent and difficult to arouse - Sustained hypotension (SBP less than 90) - Excessive nausea or vomiting - Urinary retention

☑ **IV Fluids for provision of PCA Therapy**

◉ **sodium chloride 0.9 % infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

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

○ **dextrose 5% infusion Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

○ **hydromorPHONE PCA (DILAUDID) 30 mg/30 mL + Nursing PCA Orders**

☑ **hydromorPHONE PCA (DILAUDID) 30 mg/30 mL**

○ **hydromorPHONE (DILAUDID) 30 mg/30 mL in sodium chloride 0.9% PCA for Opioid Naive Dose:** 1 **Route:** intravenous **Frequency:** continuous
Admin Instructions:
For breakthrough pain: Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. RN may bolus *** every *** hours as needed. If pain persists, may increase PCA demand dose by *** mg ONCE. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber.

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

☑ **Vital signs - T/P/R/BP Frequency:** Per unit protocol **Priority:** Routine **Comments:** - Initially and every 30 minutes for 1 hour after PCA started, bolus administration or dose change; then - Every hour x 2 starting second hour after PCA started, bolus administered or dose change; then - Every 4 hours until PCA therapy is discontinued. - Immediately following PCA administration tubing change

☑ **PCA Documentation Frequency:** Every 12 hours **Priority:** Routine **Comments:** At the beginning (or end of each shift), prior to clearing PCA pump data, the following must be documented: doses delivered, number of attempts, total amount of medication infused (in mg or mcg), and volume remaining in syringe (residual volume).

☑ **Patient education Pain pump Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Comments:** Provide patient education on appropriate use of PCA including no PCA by proxy. Only the patient may press the dosing button.
Question(s):
Education for: ○ Pain pump
Patient/Family:

☑ **Pasero Opioid-induced Sedation Scale Frequency:** Every 6 hours **Start Date:** S **Priority:** Routine **Comments:** Assess POSS while patient has an active PCA order. Contact provider if score 3 or 4.

☑ **Notify Physician Frequency:** Until discontinued **Priority:** Routine **Comments:** - PCA pump infusion discontinued for any reason - Inadequate analgesia - Prior to administration of any other narcotics, antiemetics, or sedatives other than those ordered by the prescriber responsible for IV PCA therapy - PCA pump discontinued by any service other than the prescriber responsible for IV PCA therapy

☑ **Stop the PCA pump and call ordering physician and/or CERT team for any of the following: Frequency:** Until discontinued **Priority:** Routine **Comments:** - Respiratory rate 10 per minute or less - Severe and/or recent confusion or disorientation - POSS sedation level 4: Somnolent and difficult to arouse - Sustained hypotension (SBP less than 90) - Excessive nausea or vomiting - Urinary retention

☑ **IV Fluids for provision of PCA Therapy**

◉ **sodium chloride 0.9 % infusion Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

○ **dextrose 5% infusion Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

○ **morPHINE PCA 30 mg/30 mL + Nursing PCA Orders**

☑ **morPHINE PCA 30 mg/30 mL**

○ **morPHINE PCA 30 mg/30 mL in sodium chloride 0.9% for Opioid Naive Dose:** 3 **Route:** intravenous **Frequency:** continuous
Admin Instructions:
For breakthrough pain: Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. RN may bolus *** every *** hours as needed. If pain persists, may increase PCA demand dose by *** mg ONCE. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber.

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

☑ **Vital signs - T/P/R/BP Frequency:** Per unit protocol **Priority:** Routine **Comments:** - Initially and every 30 minutes for 1 hour after PCA started, bolus administration or dose change; then - Every hour x 2 starting second hour after PCA started, bolus administered or dose change; then - Every 4 hours until PCA therapy is discontinued. - Immediately following PCA administration tubing change

☑ **PCA Documentation Frequency:** Every 12 hours **Priority:** Routine **Comments:** At the beginning (or end of each shift), prior to clearing PCA pump data, the following must be documented: doses delivered, number of attempts, total amount of medication infused (in mg or mcg), and volume remaining in syringe (residual volume).

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

☑ **Patient education Pain pump** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Comments:** Provide patient education on appropriate use of PCA including no PCA by proxy. Only the patient may press the dosing button.
Question(s):
Education for: ○ Pain pump
Patient/Family:

☑ **Pasero Opioid-induced Sedation Scale** **Frequency:** Every 6 hours **Start Date:** S **Priority:** Routine **Comments:** Assess POSS while patient has an active PCA order. Contact provider if score 3 or 4.

☑ **Notify Physician** **Frequency:** Until discontinued **Priority:** Routine **Comments:** - PCA pump infusion discontinued for any reason - Inadequate analgesia - Prior to administration of any other narcotics, antiemetics, or sedatives other than those ordered by the prescriber responsible for IV PCA therapy - PCA pump discontinued by any service other than the prescriber responsible for IV PCA therapy

☑ **Stop the PCA pump and call ordering physician and/or CERT team for any of the following:** **Frequency:** Until discontinued **Priority:** Routine **Comments:** - Respiratory rate 10 per minute or less - Severe and/or recent confusion or disorientation - POSS sedation level 4: Somnolent and difficult to arouse - Sustained hypotension (SBP less than 90) - Excessive nausea or vomiting - Urinary retention

☑ **IV Fluids for provision of PCA Therapy**

◉ **sodium chloride 0.9 % infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

○ **dextrose 5% infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous

Mild Pain (Pain Score 1-3) or Fever

☐ **acetaminophen (TYLENOL) tablet** **Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** mild pain (score 1-3)
fever
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Contact physician for fever GREATER than 101 F
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

Oral for Moderate Pain (Pain Score 4-6)

○ **HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **HYDROcodone-acetaminophen (NORCO) 7.5-325 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **traMADol (ULTRAM) tablet** **Dose:** 50 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **oxyCODONE-acetaminophen (PERCOCET) 5-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule. Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

IV for Moderate Pain (Pain Score 4-6)

If you select a PCA option you will not be allowed to also order IV PRN pain medications from this section.

○ **morPHINE injection Dose:** 1 mg **Route:** intravenous **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Give if patient cannot tolerate oral medications or a faster onset of action is required.

Oral for Severe Pain (Pain Score 7-10)

○ **HYDROcodone-acetaminophen (NORCO 10-325) 10-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication

○ **traMADol (ULTRAM) tablet Dose:** 100 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **oxyCODone-acetaminophen (PERCOCET) 10-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

IV for Severe Pain (Pain Score 7-10)

If you select a PCA option you will not be allowed to also order IV PRN pain medications from this section.

○ **morPHINE injection Dose:** 2 mg **Route:** intravenous **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Give if patient cannot tolerate oral medications or a faster onset of action is required.

○ **hydromorPHONE (DILAUDID) injection Dose:** 0.2 mg **Route:** intravenous **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

Respiratory

☑ **naloxone (NARCAN) injection Dose:** 0.2 mg **Route:** intravenous **Frequency:** once PRN **Phase of Care:** Post-op **Priority:** Routine **PRN Comment:** as needed for respiratory rate 8 per minute or less OR patient somnolent and difficult to arouse (POSS GREATER than 3). **PRN Reasons:** respiratory depression
Admin Instructions:
Repeat Naloxone 0.2 mg once in 2 minutes if necessary (MAXIMUM 0.4 mg).
If naloxone is needed, please call the ordering physician and/or CERT team. Monitor vital signs (pulse oximetry, P/R/BP) every 15 minutes for 3 times.

Bowel Care - NOT HMSJ

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

☐ **docusate sodium (COLACE) capsule** **Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** constipation
Admin Instructions:
Use docusate for stool softener as needed.

☐ **simethicone (MYLICON) chewable tablet** **Dose:** 160 mg **Route:** oral **Frequency:** 4 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** flatulence

☐ **bisacodyl (DULCOLAX) suppository** **Dose:** 10 mg **Route:** rectal **Frequency:** daily PRN **Phase of Care:** Post-op **PRN Reasons:** constipation
Admin Instructions:
Suppository can be used if oral therapy is not tolerated or ineffective.

☐ **senna (SENOKOT) tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** 2 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** constipation

☐ **diphenoxylate-atropine (LOMOTIL) 2.5-0.025 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** 4 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** diarrhea

Antiemetics - HMSL, HMWB, HMCY Only

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

◉ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet** **Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
May cause QTc prolongation.

◉ **ondansetron (ZOFRAN) 4 mg/2 mL injection** **Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Product Admin Instructions:
May cause QTc prolongation.

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

◉ **promethazine (PHENERGAN) injection** **Dose:** 12.5 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

◉ **promethazine (PHENERGAN) tablet** **Dose:** 12.5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is able to tolerate oral medication.

◉ **promethazine (PHENERGAN) suppository** **Dose:** 12.5 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

Antiemetics - HMH, HMSJ, HMW, HMSTC, HMTW Only

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

◉ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet** **Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
May cause QTc prolongation.

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

◉ **ondansetron (ZOFRAN) 4 mg/2 mL injection** **Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Product Admin Instructions:
May cause QTc prolongation.

☑ **promethazine (PHENERGAN)**

◉ **promethazine (PHENERGAN) 12.5 mg IV** **Dose:** 12.5 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

◉ **promethazine (PHENERGAN) tablet** **Dose:** 12.5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

◉ **promethazine (PHENERGAN) suppository** **Dose:** 12.5 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

◉ **promethazine (PHENERGAN) intraMUSCULAR injection** **Dose:** 12.5 mg **Route:** intramuscular **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

Antiemetics - HMSTJ Only

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

◉ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet** **Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
May cause QTc prolongation.

◉ **ondansetron (ZOFRAN) 4 mg/2 mL injection** **Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Product Admin Instructions:
May cause QTc prolongation.

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

◉ **promethazine (PHENERGAN) 25 mg in sodium chloride 0.9 % 50 mL IVPB** **Dose:** 12.5 mg **Route:** intravenous **Frequency:** every 6 hours PRN **Minimum Infusion Duration:** 30.000 Minutes **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

◉ **promethazine (PHENERGAN) tablet** **Dose:** 12.5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is able to tolerate oral medication.

◉ **promethazine (PHENERGAN) suppository Dose:** 12.5 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral medication.

Itching: For Patients GREATER than 77 years old

○ **cetirizine (ZyrTEC) tablet Dose:** 5 mg **Route:** oral **Frequency:** daily PRN **Phase of Care:** Post-op **PRN Reasons:** itching

Itching: For Patients between 70-76 years old

○ **cetirizine (ZyrTEC) tablet Dose:** 5 mg **Route:** oral **Frequency:** daily PRN **Phase of Care:** Post-op **PRN Reasons:** itching

Itching: For Patients LESS than 70 years old

○ **diphenhydrAMINE (BENADRYL) tablet Dose:** 25 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** itching

○ **hydrOXYzine (ATARAX) tablet Dose:** 10 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** itching

○ **cetirizine (ZyrTEC) tablet Dose:** 5 mg **Route:** oral **Frequency:** daily PRN **Phase of Care:** Post-op **PRN Reasons:** itching

○ **fexofenadine (ALLEGRA) tablet - For eGFR LESS than 80 mL/min, reduce frequency to once daily as needed Dose:** 60 mg **Route:** oral **Frequency:** 2 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** itching

Insomnia: For Patients GREATER than 70 years old

○ **ramelteon (ROZEREM) tablet Dose:** 8 mg **Route:** oral **Frequency:** nightly PRN **Phase of Care:** Post-op **PRN Reasons:** sleep

Insomnia: For Patients LESS than 70 years old

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

○ **zolpidem (AMBIEN) tablet Dose:** 5 mg **Route:** oral **Frequency:** nightly PRN **PRN Reasons:** sleep

○ **ramelteon (ROZEREM) tablet Dose:** 8 mg **Route:** oral **Frequency:** nightly PRN **PRN Reasons:** sleep

VTE

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:**_____

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

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

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **LOW Risk of VTE** (Required)

☑ **Low Risk** (Required)

◉ **Low risk of VTE** **Frequency:** Once **Priority:** Routine
Question(s):
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)

☑ **Moderate Risk** (Required)

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

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

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

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
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**

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

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
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 Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
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 Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Moderate Risk** (Required)

☑ **Moderate risk of VTE Frequency:** Once **Priority:** Routine

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

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

☑ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
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:

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

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 Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
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 Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
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.

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

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

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
No pharmacologic 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:

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

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 Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
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 Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
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.

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

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

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
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 Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
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 Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

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

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

○ **aspirin chewable tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

○ **aspirin (ECOTRIN) enteric coated tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

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

☑ **apixaban (ELIQUIS) tablet Dose:** 2.5 mg **Frequency:** 2 times daily **Start Date:** S+1
Question(s):
Indications: ○ VTE prophylaxis

☑ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy Frequency:** Until discontinued **Priority:** STAT
Question(s):
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:

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

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 Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
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 Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
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.

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

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

☑ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission Dose:** 10 mg **Frequency:** daily at 0600 (TIME CRITICAL)
Question(s):
Indications: ○ VTE prophylaxis
Admin Instructions:
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 Frequency:** Until discontinued **Priority:** STAT
Question(s):
Indications: VTE prophylaxis

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
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:**_____

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

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

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **LOW Risk of VTE** (Required)

☑ **Low Risk** (Required)

◉ **Low risk of VTE** **Frequency:** Once **Priority:** Routine
Question(s):
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)

☑ **Moderate Risk** (Required)

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

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

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

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
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**

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

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
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 Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
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 Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Moderate Risk** (Required)

☑ **Moderate risk of VTE Frequency:** Once **Priority:** Routine

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

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

☑ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
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:

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

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 Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
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 Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
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.

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

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

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
No pharmacologic 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:

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

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 Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
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 Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
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.

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

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

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
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 Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
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 Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

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

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

○ **aspirin chewable tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

○ **aspirin (ECOTRIN) enteric coated tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

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

☑ **apixaban (ELIQUIS) tablet Dose:** 2.5 mg **Frequency:** 2 times daily **Start Date:** S+1
Question(s):
Indications: ○ VTE prophylaxis

☑ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy Frequency:** Until discontinued **Priority:** STAT
Question(s):
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:

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

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 Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
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 Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
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.

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

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

☑ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission Dose:** 10 mg **Frequency:** daily at 0600 (TIME CRITICAL)
Question(s):
Indications: ○ VTE prophylaxis
Admin Instructions:
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 Frequency:** Until discontinued **Priority:** STAT
Question(s):
Indications: VTE prophylaxis

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

Labs Today

Hematology/Coagulation

☐ **Hemoglobin and hematocrit Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **CBC with platelet and differential Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Prothrombin time with INR Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☐ **Partial thromboplastin time** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Do not draw blood from the arm that has heparin infusion. Do not draw from heparin flushed lines. If there is no other access other than the heparin line, then stop the heparin, flush the line, and aspirate 20 ml of blood to waste prior to drawing a specimen.

Chemistry

☐ **Basic metabolic panel** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Magnesium** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Calcium** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Thromboelastograph** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Anticoagulant Therapy:
Diagnosis:
Fax Number (For TEG Graph Result):
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

☐ **Thromboelastograph** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

Labs Tomorrow

Hematology/Coagulation

☐ **Hemoglobin and hematocrit** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **CBC with platelet and differential** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Prothrombin time with INR** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Partial thromboplastin time** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Do not draw blood from the arm that has heparin infusion. Do not draw from heparin flushed lines. If there is no other access other than the heparin line, then stop the heparin, flush the line, and aspirate 20 ml of blood to waste prior to drawing a specimen.

Chemistry

☐ **Basic metabolic panel** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Magnesium** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Calcium** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Thromboelastograph - In AM on post-operative day #1** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** In AM on post-operative day #1
Question(s):
Anticoagulant Therapy:
Diagnosis:
Fax Number (For TEG Graph Result):
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

☐ **Thromboelastograph - In AM on post-operative day #1** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** In AM on post-operative day #1
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

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

☐ **Thromboelastograph - at noon on post-operative day #1** **Frequency:** Timed **Frequency Limit:** 1 Occurrences **Start Date:** S+1 **Start Time:** 1200 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Comments: At Noon on post-operative day #1
Question(s):
Anticoagulant Therapy:
Diagnosis:
Fax Number (For TEG Graph Result):
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

☐ **Thromboelastograph - at noon on post-operative day #1** **Frequency:** Timed **Frequency Limit:** 1 Occurrences **Start Date:** S+1 **Start Time:** 1200 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Comments: At Noon on post-operative day #1
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

Cardiology

Imaging

X-Ray

☐ **Chest 1 Vw Portable** **Frequency:** 1 time imaging **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Other Studies

Respiratory

Respiratory

☑ **Incentive spirometry instructions** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Frequency of use: ○ Every hour while awake

Rehab

Consults

For Physician Consult orders use sidebar

Ancillary Consults

☐ **Consult to Case Management** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Consult Reason:
Reason for Consult?
Process Instructions:
If Ordering IV antimicrobial therapy, an additional consult to Case Management OPAT order is needed.

☐ **Consult to Social Work** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for Consult:
Reason for Consult?

☐ **Consult to PT Wound Care Eval and Treat** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Special Instructions:
Location of Wound?
Reason for PT?

☐ **Consult to PT eval and treat** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
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?
Process Instructions:
If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting physical therapy

If the patient currently has an order for bed rest, please consider revising the activity order to accommodate therapy

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

☐ **Consult OT eval and treat** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
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?
Process Instructions:
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** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason For Consult?
Purpose/Topic:
Reason for Consult?

☐ **Consult to Spiritual Care** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for consult?
Reason for Consult?
Process Instructions:
For requests after hours, call the house operator.

☐ **Consult to Speech Language Pathology** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for consult:
Reason for SLP?

☐ **Consult to Wound Ostomy Care nurse** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for consult:
Reason for consult:
Reason for consult:
Reason for consult:
Consult for NPWT:
Reason for consult:
Reason for consult:
Reason for Consult?
Process Instructions:
This is NOT for PT Wound Care Consult order.

☐ **Consult to Respiratory Therapy** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for Consult?
Reason for Consult?

Additional Orders

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