Location: _____

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

Admission or Observation

- ○ **Admit to Inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** Scheduling/ADT **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.

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

◯ **Outpatient observation services under general supervision** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

◯ **Outpatient in a bed - extended recovery** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

Admission or Observation

Patient has active status order on file

◯ **Admit to Inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** Scheduling/ADT **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:** Scheduling/ADT **Priority:** Routine
Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

◯ **Outpatient in a bed - extended recovery** **Frequency:** Once **Phase of Care:** Scheduling/ADT **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:** Scheduling/ADT **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

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

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

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

○ **Full code Frequency:** Continuous **Phase of Care:** Post-op **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 **Phase of Care:** Post-op **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**

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

- [x] **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 General

Vital Signs

- [x] **Vital signs - T/P/R/BP** **Frequency:** Every 15 min **Phase of Care:** Post-op **Priority:** Routine **Comments:** Vital signs every 15 minutes x 2 hours, every 30 minutes x 4 hours, and then every hour after that
- [ ] **Vital signs - T/P/R/BP** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine

Nursing Care

- [ ] **Intake and output** **Frequency:** Per unit protocol **Phase of Care:** Post-op **Priority:** Routine
- [ ] **Do not remove Foley** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
  Question(s):
  Rationale:
- [ ] **Foley catheter care** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
  Question(s):
  Orders: ○ Maintain ○ to gravity
- [ ] **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:
- [x] **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine **Comments:** Bilateral at all times
  Question(s):
  Side: Bilateral
  Select Sleeve(s):
- [ ] **Keep room temperature at 76 degrees F.** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
- [ ] **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

Flap Assessment

- [ ] **Flap assessment** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine **Comments:** Notify plastic surgery resident on call and attending/faculty surgeon for ANY questions regarding the flap.
  Question(s):
  Side:
  Location:

Wound/Drain Care

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

☐ **Drain care: To bulb suction. Attach bulbs to gown with safety pins. Do NOT tape drains to patient.. Strip tubing and record output ever 4 hours** **Frequency:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
All Drains: ○ Jackson Pratt
Care Details: Attach bulbs to gown with safety pins. Do NOT tape drains to patient. Record output every time bulb is emptied.
Drainage/Suction: ○ To Compression (Bulb) Suction ○ Strip tubing
Drain 1:
Drain 2:
Drain 3:
Drain 4:

☐ **Provide equipment / supplies at bedside: Adaptic, Hydrogen peroxide, 4x4 Gauze, Kerlix, Q-Tips, Saline, Suture removal kit** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Supplies: ○ Adaptic ○ Hydrogen peroxide ○ 4X4 Gauze ○ Kerlix ○ Q-Tips ○ Saline ○ Suture removal kit

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

☐ **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:** Every 12 hours **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.

Notify

☐ **Notify Plastic Surgeon for approval prior to administering any vasopressors or diuretic drugs** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Notify Physician (Specify)** **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.

☐ **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.

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

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

Nursing: Facial Reanimation

Activity/Positioning

☐ **Strict bed rest** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Head of Bed elevated 45-80 degrees, bed in flex position at hips.

☐ **Head of bed 45 degrees** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** 45-80 degrees
Question(s):
Head of bed: ○ 45 degrees

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

☐ **Patient position: no pillow under head** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Comments: No pillow under head
Question(s):
Position:
Additional instructions:

Nursing Care

☐ **No brushing teeth** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **No incentive spirometry** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **No pressure on face** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **No straws** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** OK to sip from cup or use a syringe

☐ **Assess cheek for signs of hematoma** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Assess: ○ cheek for signs of hematoma

☐ **Encourage deep breathing** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

Nursing: Head and Neck

Activity/Positioning

☐ **Strict bed rest** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Head of Bed elevated 45-80 degrees, bed in flex position at hips.

☐ **Head of bed 45 degrees** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** 45-80 degrees
Question(s):
Head of bed: ○ 45 degrees

☐ **Patient position: no pillows under head** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Comments: no pillows under head
Question(s):
Position:
Additional instructions:

☐ **No trach ties** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Nothing around neck** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Patient position: no moving head side to side** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Comments: no moving head side to side
Question(s):
Position:
Additional instructions:

☐ **Patient position: place rolled sheets on either side of head to prevent movement** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** place rolled sheets on either side of head to prevent movement
Question(s):
Position:
Additional instructions:

Nursing Care

☐ **Keep moist gauze on tongue to prevent desiccation** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

Nursing: Lower Extremity

Activity/Positioning

☐ **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.

☐ **Patient position: Elevate affected extremity** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Additional instructions: ○ elevate extremity
Position:

☐ **Do not allow extremity to dangle until dangle protocol initiated** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Keep splint in place** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

Nursing Care

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

☐ **Apply warming blanket** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Bair hugger at 43 degrees Celsius to affected extremity and cover with a blanket

☐ **Notify Orthopedics for problems with pins or device if patient has an external fixator** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Dangle protocol** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Allow patient to dangle affected extremity per specified frequency and duration. Return to elevation immediately if the flap becomes congested or patient has worsening pain and swelling. Flap checks with every position change.
Question(s):
Duration (minutes):

☐ **Heat lamp** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** To bedside
Question(s):
Duration of treatment (minutes):
Distance from site:

IV Fluids

IV Fluids

☐ **sodium chloride 0.9 % 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

☐ **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

☐ **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

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**

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

☑ **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.

☐ **vancomycin IV plus Optional Pharmacy Consult to Dose Vancomycin**

☑ **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.:

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

☐ **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.

Ophthalmic Antibiotic Ointments

○ **tobramycin-dexamethasone (TOBRADEX) ophthalmic ointment** **Dose:** 0.3-0.1 **Frequency:** 3 times daily **Phase of Care:** Post-op
Product Admin Instructions:
For Ophthalmic use only

Facial Operations

☐ **chlorhexidine (PERIDEX) 0.12 % solution** **Dose:** 15 mL **Route:** Mouth/Throat **Frequency:** 2 times daily **Phase of Care:** Post-op
Admin Instructions:
Swish and Spit

☐ **artificial tears ophthalmic solution** **Dose:** 2 drop **Route:** Both Eyes **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** dry eyes
Product Admin Instructions:
For Ophthalmic use only

☐ **artificial tears ointment** **Route:** Both Eyes **Frequency:** nightly PRN **Phase of Care:** Post-op **PRN Reasons:** dry eyes

☐ **clonIDINE HCl (CATAPRES) tablet** **Dose:** .1 **Route:** oral **Frequency:** 2 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** high blood pressure
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:

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

Anxiolytics: For Patients LESS than 65 years old

☐ **LORAZepam (ATIVAN) tablet Dose:** 1 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** anxiety
Question(s):
Indication(s): ○ Anxiety

Anxiolytics: For Patients GREATER than or EQUAL to 65 years old

☐ **LORAZepam (ATIVAN) tablet Dose:** 0.5 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** anxiety
Question(s):
Indication(s): ○ Anxiety

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 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

○ **ropivacaine 0.5% (PF) (NAROPIN) solution for On-Q Pump 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

○ **morPHINE PCA 30 mg/30 mL**

☑ **morPHINE 30 mg/30 mL PCA Dose:** 3 **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Admin Instructions:
Management of breakthrough pain. Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber. For breakthrough pain in patients ages 19-59 years old with normal renal function, may bolus {Bolus Dose:26657::"2"} mg every {Bolus Frequency:26659::"3"} hours as needed. If pain persists, may increase PCA demand dose by {PCA Dose:26660::"0.5"} mg ONCE. Adjust doses for age, renal function or other factors.

☑ **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

☑ **Pasero Opioid-induced Sedation Scale Frequency:** Once **Priority:** Routine

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

☑ **Notify Physician (Specify)** **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

☑ **naloxone (NARCAN) 0.4 mg/mL injection 0.2 mg** **Dose:** 0.2 mg **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).
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.

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

☑ **hydromorPHONE (DILAUDID) 15 mg/30 mL PCA** **Dose:** .5 **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Admin Instructions:
Management of breakthrough pain. Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber. For breakthrough pain in patients ages 19-59 years old with normal renal function, may bolus {Bolus Dose:26662::"0.2"} mg every {Bolus Frequency:26663::"3"} hours as needed. If pain persists, may increase PCA demand dose by {PCA Dose:26664::"0.1"} mg ONCE. Adjust doses for age, renal function or other factors.

☑ **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

☑ **Pasero Opioid-induced Sedation Scale** **Frequency:** Once **Priority:** Routine

☑ **Notify Physician (Specify)** **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

☑ **naloxone (NARCAN) 0.4 mg/mL injection 0.2 mg** **Dose:** 0.2 mg **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).
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.

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

☑ **fentaNYL (SUBLIMAZE) 1500 mcg/30 mL PCA** **Dose:** 50 **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Admin Instructions:
Due to fentaNYL 600 mcg/30 mL shortages, the new standard for all facilities will be fentaNYL 1500 mcg/30 mL. This concentration is 2.5 x more concentrated.

Management of breakthrough pain. Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber. For breakthrough pain in patient 19-59 years old, may bolus {Bolus Dose:26656::"25"} mcg every {Bolus Frequency:26655::"2"} hours as needed. If pain persists, may increase PCA demand dose by {PCA Dose:26654::"10"} mcg ONCE. Adjust doses for age, renal function or other factors.

☑ **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

☑ **Pasero Opioid-induced Sedation Scale** **Frequency:** Once **Priority:** Routine

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

☑ **Notify Physician (Specify)** **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

☑ **naloxone (NARCAN) 0.4 mg/mL injection 0.2 mg** **Dose:** 0.2 mg **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).
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.

PCA Medications

○ **morPHINE PCA 30 mg/30 mL**

☑ **morPHINE 30 mg/30 mL PCA** **Dose:** 3 **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Admin Instructions:
Management of breakthrough pain. Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber. For breakthrough pain in patients ages 19-59 years old with normal renal function, may bolus {Bolus Dose:26657::"2"} mg every {Bolus Frequency:26659::"3"} hours as needed. If pain persists, may increase PCA demand dose by {PCA Dose:26660::"0.5"} mg ONCE. Adjust doses for age, renal function or other factors.

☑ **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

☑ **Pasero Opioid-induced Sedation Scale** **Frequency:** Once **Priority:** Routine

☑ **Notify Physician (Specify)** **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

☑ **naloxone (NARCAN) 0.4 mg/mL injection 0.2 mg** **Dose:** 0.2 mg **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).
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.

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

☑ **hydromorPHONE (DILAUDID) 15 mg/30 mL PCA** **Dose:** .5 **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Admin Instructions:
Management of breakthrough pain. Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber. For breakthrough pain in patients ages 19-59 years old with normal renal function, may bolus {Bolus Dose:26662::"0.2"} mg every {Bolus Frequency:26663::"3"} hours as needed. If pain persists, may increase PCA demand dose by {PCA Dose:26664::"0.1"} mg ONCE. Adjust doses for age, renal function or other factors.

☑ **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

☑ **Pasero Opioid-induced Sedation Scale** **Frequency:** Once **Priority:** Routine

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

☑ **Notify Physician (Specify)** **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

☑ **naloxone (NARCAN) 0.4 mg/mL injection 0.2 mg** **Dose:** 0.2 mg **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).
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.

○ **fentaNYL PCA (SUBLIMAZE) 600 mcg/30 mL**

☑ **fentaNYL (SUBLIMAZE) 600 mcg/30 mL PCA** **Dose:** 20 **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Admin Instructions:
Management of breakthrough pain. Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber. For breakthrough pain in patient 19-59 years old, may bolus {Bolus Dose:26656::"25"} mcg every {Bolus Frequency:26655::"2"} hours as needed. If pain persists, may increase PCA demand dose by {PCA Dose:26654::"10"} mcg ONCE. Adjust doses for age, renal function or other factors.

☑ **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

☑ **Richmond agitation sedation scale** **Frequency:** Once **Priority:** Routine **Comments:** 60 minutes after administration of pain medication AND every 4 hours. Assess and document side effects of at least every 4 hours for duration of therapy and when patient complains of pain and/or side effects.
Question(s):
Hold infusion daily at:
Target RASS:
BIS Monitoring (Target BIS: 40-60):

☑ **Notify Physician (Specify)** **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

☑ **naloxone (NARCAN) 0.4 mg/mL injection 0.2 mg** **Dose:** 0.2 mg **Frequency:** once PRN **Phase of Care:** Post-op **Priority:** STAT **PRN Comment:** as needed for respiratory rate 8 per minute or less OR patient somnolent and difficult to arouse (POSS GREATER than 3).
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.

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).

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

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:
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:
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:
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:
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:

○ **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:
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:
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:
Give if patient cannot tolerate oral medications or a faster onset of action is required.

Respiratory

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

☑ **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

☐ **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

☐ **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)**

◉ **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.

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

◉ **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

☑ **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

☑ **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:** Once **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **CBC with platelet and differential** **Frequency:** Once **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Prothrombin time with INR** **Frequency:** Once **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Partial thromboplastin time** **Frequency:** Once **Start Date:** S+1 **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 **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Magnesium** **Frequency:** Once **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Calcium** **Frequency:** Once **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Thromboelastograph** **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** **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** **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** **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 **Comments:** On arrival to SICU
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Chest 1 Vw Portable** **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.):

☐ **Abdomen 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: ○ 10 times per hour

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 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 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 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:**_____