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

Elective Outpatient, Observation, or Admission

- ○ **Elective outpatient procedure: Discharge following routine recovery** **Frequency:** Continuous **Phase of Care:** PACU & Post-op **Priority:** Routine
- ○ **Outpatient observation services under general supervision** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine

Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

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

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

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

Admission or Observation

Patient has active outpatient status order on file

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

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

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

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

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

Admission

Patient has active status order on file

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

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

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

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:

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

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

Code Status

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

☑ **Code Status**

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

○ **Full code** **Frequency:** Continuous **Priority:** Routine

Question(s):

Code Status decision reached by:

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

☑ **DNR (Do Not Resuscitate)** **Frequency:** Continuous **Priority:** Routine

Question(s):

Did the patient/surrogate require the use of an interpreter?
Did the patient/surrogate require the use of an interpreter?
Does patient have decision-making capacity?
I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT Active until Signed by the Responsible Attending Physician.:
Code Status decision reached by:

☐ **Consult to Palliative Care Service**

☑ **Consult to Palliative Care Service** **Frequency:** Once **Priority:** Routine

Question(s):

Priority:
Reason for Consult?
Order?
Name of referring provider:
Enter call back number:
Reason for Consult?

Process Instructions:

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

☐ **Consult to Social Work** **Frequency:** Once **Priority:** Routine

Question(s):

Reason for Consult:
Reason for Consult?

○ **Modified Code** **Frequency:** Continuous **Priority:** Routine

Question(s):

Did the patient/surrogate require the use of an interpreter?
Did the patient/surrogate require the use of an interpreter?
Does patient have decision-making capacity?
Modified Code restrictions:
I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT Active until Signed by the Responsible Attending Physician.:
Code Status decision reached by:

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

☐ **Treatment Restrictions ((For use when a patient is NOT in a cardiopulmonary arrest))** **Frequency:** Continuous - Treatment Restrictions **Phase of Care:** Post-op **Priority:** Routine
Question(s):
I understand that if the patient is NOT in a cardiopulmonary arrest, the selected treatments will NOT be provided. I understand that all other unselected medically indicated treatments will be provided.:
Treatment Restriction decision reached by:
Specify Treatment Restrictions:
Code Status decision reached by:
Process Instructions:
Treatment Restrictions is NOT a Code Status order. It is NOT a Modified Code order. It is strictly intended for Non Cardiopulmonary situations.

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

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

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

Isolation

☐ **Airborne isolation status**

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

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

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

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

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

Precautions

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

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

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

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

Nursing

Vital Signs

☑ **Vital signs - T/P/R/BP** **Frequency:** Per unit protocol **Phase of Care:** Post-op **Priority:** Routine

Activity/Patient Position

☐ **Strict bed rest** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Up in chair in AM

☐ **Up in chair** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Post operative day ***
Question(s):
Specify: ○ Up in chair

☐ **Ambulate with assistance every 8 hours** **Frequency:** Now then every 8 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Specify: ○ with assistance

☐ **Ambulate with assistance 4 times daily and prn** **Frequency:** 4 times daily **Phase of Care:** Post-op **Priority:** Routine
Comments: And as needed
Question(s):
Specify: ○ with assistance

☐ **Activity as tolerated** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Specify: ○ Activity as tolerated

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

☐ **Avoid pressure to** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Orientation:
Location:

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

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

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

☐ **Patient position: Do not reposition** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Additional instructions: ○ do not reposition
Position:

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

Nursing Care

☐ **Neurological assessment** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Assessment to Perform:

☐ **Peripheral vascular assessment** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Assess head** **Frequency:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Assess: ○ Head (Facial, eyelids) for color, refill, hematoma. Notify Resident or staff for any changes.

☐ **Assess breast** **Frequency:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Assess: ○ Breast - assess nipple for color, refill, and hematoma. Notify Resident or staff for any changes.

☐ **Assess abdomen** **Frequency:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Assess: ○ Abdomen - assess for color, refill , and hematoma. Notify Resident or staff for any changes.

☐ **Assess On-Q Pump** **Frequency:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Assess: ○ On-Q Pump every 4 hours

☐ **Intake and output** **Frequency:** Per unit protocol **Phase of Care:** Post-op **Priority:** Routine **Comments:** Include amount from surgical drain in intake and output

☐ **No ice pack** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Unless ordered otherwise

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

☐ **May use either arm for blood pressure or needle sticks** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

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

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

☐ **Abdominal binder** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Keep abdominal binder open and loose while in bed. When patient gets up in chair, place binder on. Open when back in bed.
Question(s):
Waking hours only?
Nurse to schedule?
Special Instructions:

☐ **Compression garmet** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Intervention: ○ Release every 3 hours for 1 hour

Flap Assessment

☐ **Flap assessment** **Frequency:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** Notify Resident or staff for any changes.
Question(s):
Side:
Location:

Tubes/Drains Care

☐ **Drain care- Compression Suction; Attach bulbs to gown with safety pins. Do NOT tape drains to patient.; Strip tubing and record output every 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.
Drainage/Suction: ○ To Compression (Bulb) Suction ○ Strip tubing ○ Other (specify)
Specify: Empty drain and record output every 4 hours.
Drain 1:
Drain 2:
Drain 3:
Drain 4:

☐ **Drain care- Clean site daily with normal saline. Apply ointment and cover with gauze.** **Frequency:** Daily **Phase of Care:** Post-op **Priority:** Routine
Question(s):
All Drains: ○ Jackson Pratt
Care Details: Clean site daily with normal saline. Apply ointment and cover with gauze.
Drainage/Suction: To Compression (Bulb) Suction
Drain 1:
Drain 2:
Drain 3:
Drain 4:

☐ **Drain care- Clean site daily with peroxide. Apply bacitracin ointment and cover with gauze.** **Frequency:** Daily **Phase of Care:** Post-op **Priority:** Routine
Question(s):
All Drains: ○ Jackson Pratt
Care Details: Clean site daily with peroxide. Apply bacitracin ointment and cover with gauze.
Drainage/Suction: To Compression (Bulb) Suction
Drain 1:
Drain 2:
Drain 3:
Drain 4:

☐ **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

Wound/Incision Care

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

☐ **Surgical/incision site care- Wet to dry, Nomal Saline** **Frequency:** Every 8 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Dressing Type: ○ Moist to Dry, Normal Saline
Location:
Site:
Apply:
Open to air?

☐ **Surgical/incision site care- Wet to dry, Dakins** **Frequency:** Every 8 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Dressing Type: ○ Other
Specify: Wet to dry, Dakins
Location:
Site:
Apply:
Open to air?

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

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

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

☐ **Negative pressure wound therapy (Not a consult order)** **Frequency:** Every Mon, Wed, Fri **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Existing wound vac?
Type of Wound:
Wound Location:
Pressure (mmHg): 125
Therapy Settings:
Intensity:
Foam Type:

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

☐ **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.

Skin Graft Donor Site Care

☐ **Heat lamp** **Frequency:** 4 times daily **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Duration of treatment (minutes): ○ 15
Distance from site: ○ 2-3 feet

☐ **Skin graft donor site care** **Frequency:** 4 times daily **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Instructions: ○ Leave donor site intact for 48 hours, clean any excessive fluid leakage as needed. After 48 hours, remove clear Tegaderm but DO NOT remove Zeroform gauze. Wipe off any excess fluid gently PRN. Use heat lamp to treat donor site 4 x/day when patient is aw

☐ **Negative pressure wound therapy (Not a consult order)** **Frequency:** Every Mon, Wed, Fri **Phase of Care:** Post-op **Priority:** Routine **Comments:** DO NOT change negative pressure wound therapy dressing**
Question(s):
NPWT to be applied by: Physician
Pressure (mmHg): 125
Existing wound vac?
Type of Wound:
Wound Location:
Therapy Settings:
Intensity:
Foam Type:

Notify

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

☐ **Notify Physician or Resident of any acute changes in patient status** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** or Resident of any acute changes in patient status

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

☐ **Diet- 1800 Kcal/202 gm Carbohydrate** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Diet(s): ○ Other Diabetic/Cal
Consistent Carbohydrate: 1800 Kcal/202 gm Carbohydrate
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☐ **Diet - 1800 Kcal/202 gm Carbohydrate** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
Diet(s): ○ Consistent Carbohydrate
Consistent Carbohydrate: 1800 Kcal/202 gm Carbohydrate
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

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

☐ **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:

Education

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

☐ **Patient education- Dressing change** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Education for: ○ Other (specify)
Specify: Dressing change
Patient/Family:

☐ **Patient education- Lovenox teaching** **Frequency:** Prior to discharge **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Education for: ○ Self admin of medication ○ Other (specify)
Specify: Lovenox teaching for home administration.
Patient/Family:

☐ **Patient education- Pain pump** **Frequency:** Prior to discharge **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Patient/Family: ○ Patient
Education for: ○ Other (specify)
Specify: Pain pump

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

☐ **Patient education- Scopolamine patch teaching** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Patient/Family: ○ Both
Education for: ○ Other (specify)
Specify: Scopolamine patch side effect teaching

☐ **Patient education- Surgeons post op instructions** **Frequency:** Prior to discharge **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Education for: ○ Other (specify)
Specify: Dispense surgeon’s post op instructions prior to discharge.
Patient/Family:

IV Fluids

IV Fluids

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

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

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

☐ **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

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

Medications

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

Pharmacy Consult

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

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

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

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

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

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

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

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

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

IV Antibiotics: For Patients GREATER than 120 kg

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

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

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

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

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

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

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

Oral Antibiotics

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

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

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

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

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

Topical Antibiotics

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

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

☐ **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:

Bowel Care - NOT HMSJ

☐ **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

Laxatives - HMSJ Only

☐ **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

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

☐ **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.

☐ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per 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

Anxiolytics

☐ **LORazepam (ATIVAN) Oral or IV**

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

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

Muscle Spasms

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

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

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

Muscle Pain

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

On-Q Pump

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

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

PCA Medications - Not HMSJ

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

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

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

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

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

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

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

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

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

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

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

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

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

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

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

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

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

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

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

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

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

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

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

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

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

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

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

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

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

☑ **morPHINE PCA 30 mg/30 mL**

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

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

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

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

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

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

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

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

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

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

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

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

PCA Medications - HMSJ Only

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

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

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

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

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

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

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

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

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

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

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

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

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

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

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

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

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

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

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

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

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

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

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

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

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

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

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

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

☑ **morPHINE PCA 30 mg/30 mL**

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

Adjust doses for age, renal function or other factors.

☑ **Nursing PCA Orders**

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

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

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

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

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

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

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

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

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

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

Respiratory Depression and Somnolence

☑ **naloxone (NARCAN) injection Dose:** 0.2 mg **Route:** intravenous **Frequency:** once PRN **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.

Mild Pain (Pain Score 1-3) or Fever

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

Oral for Moderate Pain (Pain Score 4-6)

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

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

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

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

IV for Moderate Pain (Pain Score 4-6)

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

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

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

○ **Adjunct Medication Option: ketorolac (TORADOL) IV**

Do NOT use in patients with eGFR LESS than 30 mL/min AND/OR patients LESS than 17 years of age. WARNING: Use is contraindicated for treatment of perioperative pain OR in the setting of coronary artery bypass graft (CABG) surgery.

○ **For patients ages GREATER than 64 OR weight LESS than 50 kg OR eGFR 30-59 mL/min - ketorolac (TORADOL) injection Dose:** 15 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:

○ **For patients ages 17-64 AND weight GREATER than or EQUAL to 50 kg AND eGFR at least 60 mL/min - ketorolac (TORADOL) injection Dose:** 30 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:

Oral for Severe Pain (Pain Score 7-10)

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

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

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

IV for Severe Pain (Pain Score 7-10)

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

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

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

Post-Op Pain Medications: Additional

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

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

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

☑ **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.

◉ **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 - HMSL, HMWB, HMCY Only

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

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

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

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

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

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

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

Antiemetics - HMSTJ Only

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

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

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

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

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

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

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

Itching: For Patients GREATER than 77 years old

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

Itching: For Patients between 70-76 years old

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

Itching: For Patients LESS than 70 years old

○ **diphenhydramine (BENADRYL) injection OR oral**

◉ **diphenhydrAMINE (BENADRYL) tablet Dose:** 25 mg **Route:** oral **Frequency:** once PRN **PRN Reasons:** itching
Admin Instructions:
To be used for Acetylcysteine Induced itching

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

◉ **diphenhydrAMINE (BENADRYL) injection Dose:** 25 mg **Route:** intravenous **Frequency:** once PRN **PRN Reasons:** itching
Admin Instructions:
To be used for Acetylcysteine Induced 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

Labs Tomorrow

Hematology/Coagulation

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

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

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

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

Chemistry

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

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

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

Cardiology

Imaging

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 every 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?

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

☐ **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

☐ **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 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:**_____