Location: _____

General

HM IP PSYCHIATRY PRESENT ON ADMISSION

- ☐ **Bipolar I disorder, current episode manic, severe** **Frequency:** Once **Priority:** Routine
- ☐ **Major Depression Disorder, severe, recurrent, without psychotic features** **Frequency:** Once **Priority:** Routine
- ☐ **Alcohol withdrawal** **Frequency:** Once **Priority:** Routine
- ☐ **Psychosis, unspecified psychosis type** **Frequency:** Once **Priority:** Routine
- ☐ **Schizophrenia Disorder** **Frequency:** Once **Priority:** Routine
- ☐ **Schizoaffective Disorder** **Frequency:** Once **Priority:** Routine
- ☐ **Substance Induced Mood Disorder** **Frequency:** Once **Priority:** Routine

HM IP ADMIT TO PSYCHIATRY (Required)

- ◉ **Admit to psychiatry** **Frequency:** Once **Priority:** Routine

Question(s):
Admitting Physician:
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.

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?

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

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

☐ **Treatment Restrictions ((For use when a patient is NOT in a cardiopulmonary arrest))** **Frequency:** Continuous - Treatment Restrictions **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.

Precautions

If this is an INVOLUNTARY Admission, please order the Elopement Risk.

☑ **Suicide precautions** **Frequency:** Continuous **Priority:** Routine
Question(s):
Increased observation level needed:

☐ **Seizure precautions** **Frequency:** Continuous **Priority:** Routine
Question(s):
Increased observation level needed:

☐ **Elopement risk** **Frequency:** Continuous **Priority:** Routine
Question(s):
Increased observation level needed:

☐ **Fall precautions** **Frequency:** Continuous **Priority:** Routine
Question(s):
Increased observation level needed:

☐ **Aggressive precautions** **Frequency:** Continuous **Priority:** Routine
Question(s):
Increased observation level needed:

☐ **Bizarre precautions** **Frequency:** Continuous **Priority:** Routine
Question(s):
Increased observation level needed:

Nursing

Vital Signs

☑ **Vital signs - T/P/R/BP** **Frequency:** Per unit protocol **Start Date:** S **Priority:** Routine

☐ **Vital signs - T/P/R/BP** **Frequency:** Every 4 hours **Start Date:** S **Priority:** Routine

Nursing

☐ **1:1 patient** **Frequency:** Continuous **Priority:** Routine

☐ **Clinical institute withdrawal assessment** **Frequency:** Every 4 hours **Priority:** Routine

☐ **Clinical opiate withdrawal scale (COWS) screening** **Frequency:** Every 4 hours **Priority:** Routine

☑ **Search all clothes and belongings** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine

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

☑ **Safety search** **Frequency:** Per unit protocol **Priority:** Routine **Comments:** Perform a safety search and skin assessment per procedure

Restrictions

☑ **Restrict to unit** **Frequency:** Continuous **Priority:** Routine

Diet

☑ **Diet - Regular with Safety Tray** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
Diet(s): ○ Regular
Other Options: ○ Safety Tray
Cultural/Special:
Cultural/Special:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

IV Fluids

Medications

PRN Anxiety/Agitation

○ **diphenhydrAMINE (BENADRYL) tablet** **Dose:** 25 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** agitation

○ **diphenhydrAMINE (BENADRYL) injection** **Dose:** 25 mg **Route:** intramuscular **Frequency:** every 6 hours PRN **PRN Comment:** Severe agitation and Refusal of PO **PRN Reasons:** agitation

○ **haloperidol (HALDOL) tablet** **Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** agitation
Question(s):
Indication:
Product Admin Instructions:
May cause QTc prolongation.

○ **haloperidol (HALDOL) injection** **Dose:** 5 mg **Route:** intramuscular **Frequency:** every 6 hours PRN **PRN Comment:** and Refusal of PO. **PRN Reasons:** agitation
Question(s):
Indication:
Product Admin Instructions:
May cause QTc prolongation.

○ **hydrOXYzine (ATARAX) tablet** **Dose:** 25 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Reasons:** anxiety

○ **LORAZepam (ATIVAN) tablet** **Dose:** 2 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** anxiety
withdrawal
agitation
Question(s):
Indication(s):

○ **LORAZepam (ATIVAN) injection** **Dose:** 2 mg **Route:** intramuscular **Frequency:** every 6 hours PRN **PRN Comment:** and Refusal of PO **PRN Reasons:** agitation
withdrawal
Question(s):
Indication(s):

○ **chlordiazePOXIDE (LIBRIUM) capsule** **Dose:** 25 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** anxiety
withdrawal
Question(s):
Indication(s):

○ **OLANZapine (ZYPREXA) tablet** **Dose:** 2.5 **Route:** oral **Frequency:** daily PRN
Question(s):
Indication:
Product Admin Instructions:
May cause QTc prolongation.

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

○ **OLANZapine (ZyPREXA) injection - DO NOT give within 4 hours of IM lorazepam (ATIVAN) injection Dose:** 10 **Route:** intramuscular **Frequency:** daily PRN **PRN Reasons:** agitation
Question(s):
Indication:
Admin Instructions:
NOT to give within 4 hours of IM lorazepam (ATIVAN) injection
Product Admin Instructions:
Dissolve contents of the vial completely using 2.1 mL of SWFI to provide a solution containing approximately 5 mg/ml. Resulting solution should be clear and yellow. Use solution within 1 hour.

○ **ziprasidone (GEODON) injection Dose:** 20 mg/mL **Route:** intramuscular **Frequency:** daily PRN **PRN Reasons:** agitation
Question(s):
Indication:
Admin Instructions:
May cause QTc prolongation. For intraMUSCULAR use ONLY.
Product Admin Instructions:
Reconstitute w/ 1.2 mL of Sterile Water for a final concentration of 20mg/mL shake vigorously until completely dissolved. For IntraMUSCULAR administration only. HAZARDOUS-handle with care.

Bowel Care

☐ **loperamide (IMODIUM) capsule Dose:** 2 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** diarrhea
Admin Instructions:
Do NOT exceed 16mg per 24 hours

☐ **alum-mag hydroxide-simeth (MAALOX) 200-200-20 mg/5 mL suspension Dose:** 30 mL **Route:** oral **Frequency:** every 4 hours PRN **PRN Reasons:** indigestion
Admin Instructions:
Do NOT give if patient is on hemodialysis or with CrCl < 30 mL/min.

☐ **magnesium hydroxide suspension Dose:** 30 mL **Route:** oral **Frequency:** every 12 hours PRN **PRN Reasons:** constipation

Sleeping Aid: For Patients LESS than 70 years old

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

○ **traZODone (DESYREL) tablet Dose:** 100 mg **Route:** oral **Frequency:** nightly **PRN Reasons:** sleep
Question(s):
Indication:

Sleeping Aid: For Patients GREATER than 70 years old

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

Nicotine with Patch Removal

Dosing suggestions for nicotine patch:

Number of cigarettes per day
Less than 10, patients with heart disease or weighing less than 100 pounds (45 kg)
10-20
21-40
Greater than 40

☑ **NICOTINE PATCH HM PANEL**

○ **nicotine (NICODERM CQ) 7 mg/24 hr Dose:** 1 patch **Route:** transdermal **Frequency:** daily
Question(s):
Time to remove patch:

○ **nicotine (NICODERM CQ) 14 mg/24 hr Dose:** 1 patch **Route:** transdermal **Frequency:** daily
Question(s):
Time to remove patch:

○ **nicotine (NICODERM CQ) 21 mg/24 hr Dose:** 1 patch **Route:** transdermal **Frequency:** daily
Question(s):
Time to remove patch:

○ **nicotine (NICODERM CQ) 42 mg/24 hr Dose:** 2 patch **Route:** transdermal **Frequency:** daily
Question(s):
Time to remove patch:

☐ **Nicotine Gum**

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

☑ **nicotine polacrilex (NICORETTE) gum** **Dose:** 2 **Route:** Mouth/Throat **Frequency:** every 2 hour PRN **Frequency Limit:** 24 Hours

Labs

Laboratory

☑ **Hemoglobin A1c** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Basic metabolic panel** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Comprehensive metabolic panel** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Lipid panel** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatic function panel** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **CBC with platelet and differential** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **TSH** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **T4, free** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Ammonia level** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Specimen must be placed on ice and delivered immediately to the Core Laboratory.

☐ **Magnesium level** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lithium level** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Valproic acid level** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Carbamazepine level** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Vitamin B12 level** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Vitamin D 25 hydroxy level** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Urinalysis, automated with microscopy** **Frequency:** Once **Priority:** Routine **Specimen Type:** Urine
Primary Ordering Comments:
Specimen must be received in the laboratory within 2 hours of collection.

☐ **hCG qualitative, urine** **Frequency:** Once **Priority:** Routine **Specimen Type:** Urine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Urine drugs of abuse screen** **Frequency:** Once **Priority:** Routine **Specimen Type:** Urine

☑ **HIV 1/2 antigen/antibody, fourth generation, with reflexes** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☑ **Syphilis treponema screen with RPR confirmation (reverse algorithm)** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

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

☐ **hCG qualitative, serum screen** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Cardiology

Cardiology

☐ **ECG 12 lead** **Frequency:** Once **Priority:** STAT **Maximum Quantity:** 6 **Comments:** Evaluate QT interval
Question(s):
Clinical Indications:
Interpreting Physician:

Rehab

Consults

For Physician Consult orders use sidebar

Ancillary Consults

☑ **Consult to Psychiatric OT eval and treat** **Frequency:** Once **Priority:** Routine **Comments:** Patient may begin to participate in therapy
Question(s):
Special Instructions:
Reason for OT?

☑ **Consult to Social Work** **Frequency:** Once **Priority:** Routine **Comments:** Patient may begin to participate in Group and or Psychological education
Question(s):
Reason for Consult: ○ Other Specify
Specify: Patient may begin to participate in Group and or Psychological education
Reason for Consult?

☐ **Consult to Case Management** **Frequency:** Once **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 PT eval and treat** **Frequency:** Once **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 **Priority:** Routine
Question(s):
Special Instructions:
Location of Wound?
Reason for PT?

☐ **Consult OT eval and treat** **Frequency:** Once **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.

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

☐ **Consult to Nutrition Services** **Frequency:** Once **Priority:** Routine
Question(s):
Reason For Consult?
Purpose/Topic:
Reason for Consult?

☐ **Consult to Spiritual Care** **Frequency:** Once **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 **Priority:** Routine
Question(s):
Reason for consult:
Reason for SLP?

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

☐ **Consult to Respiratory Therapy** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult?
Reason for Consult?

Additional Orders

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