Location: _____

General

Admission or Observation (Required)

◯ **Admit to inpatient** **Frequency:** Once **Ordering Quantity:** 1 **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.

◯ **Admit to IP- University Teaching Service** **Frequency:** Once **Priority:** Routine
Question(s):
Admitting Physician:
Resident Physician:
Resident team assignment:
Level of Care:
Patient Condition:
Bed request comments:
Certification: I certify that based on my best clinical judgement 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.
Process Instructions:
To reach the team taking care of this patient please call the University Teaching Service Answering Service at (713) 363-9648 and ask for the team taking care of the patient to be paged. The team name is listed in both "Treatment Teams" and "Notes from Clinical Staff" sections in the Summary\Overview tab of Epic.

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

◯ **UTS - Outpatient observation services under general supervision** **Frequency:** Once **Priority:** Routine
Question(s):
Admitting Physician:
Resident Physician:
Resident team assignment:
Patient Condition:
Bed request comments:
Process Instructions:
To reach the team taking care of this patient please call the University Teaching Service Answering Service at (713) 363-9648 and ask for the team taking care of the patient to be paged. The team name is listed in both "Treatment Teams" and "Notes from Clinical Staff" sections in the Summary\Overview tab of Epic.

◯ **Outpatient in a bed - extended recovery** **Frequency:** Once **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

Admission or Observation

Patient has active status order on file

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

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

◯ **Admit to IP- University Teaching Service** **Frequency:** Once **Priority:** Routine
Question(s):
Admitting Physician:
Resident Physician:
Resident team assignment:
Level of Care:
Patient Condition:
Bed request comments:
Certification: I certify that based on my best clinical judgement 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.
Process Instructions:
To reach the team taking care of this patient please call the University Teaching Service Answering Service at (713) 363-9648 and ask for the team taking care of the patient to be paged. The team name is listed in both "Treatment Teams" and "Notes from Clinical Staff" sections in the Summary\Overview tab of Epic.

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

◯ **UTS - Outpatient observation services under general supervision** **Frequency:** Once **Priority:** Routine
Question(s):
Admitting Physician:
Resident Physician:
Resident team assignment:
Patient Condition:
Bed request comments:
Process Instructions:
To reach the team taking care of this patient please call the University Teaching Service Answering Service at (713) 363-9648 and ask for the team taking care of the patient to be paged. The team name is listed in both "Treatment Teams" and "Notes from Clinical Staff" sections in the Summary\Overview tab of Epic.

◯ **Outpatient in a bed - extended recovery** **Frequency:** Once **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

Admission

Patient has active status order on file.

◯ **Admit to inpatient** **Frequency:** Once **Ordering Quantity:** 1 **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 (Required)

◯ **Admit to inpatient** **Frequency:** Once **Ordering Quantity:** 1 **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 **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 **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

Admission or Observation
Patient has status order on file

○ **Admit to inpatient** **Frequency:** Once **Ordering Quantity:** 1 **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 **Priority:** Routine
Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

○ **Outpatient in a bed - extended recovery** **Frequency:** Once **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

Observation Order
Patient has Inpatient status order on file and is Medicare. Place **Consult to Case Management for Status Change** order to evaluate for Code 44 status change to Observation

○ **Consult to Case Management for Status Change** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for staus change:
Reason for Consult?

Observation Order
Patient has Inpatient status order on file. Are you sure you want to downgrade to Observation?

○ **Outpatient observation services under general supervision** **Frequency:** Once **Priority:** Routine
Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

Admission Order

☑ **Admit to long term acute care facility** **Frequency:** Once **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:
Certification: I certify that based on my best clinical judgement 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 (Required)
@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)

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

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

☐ **Consult to Palliative Care Service**

☑ **Consult to Palliative Care Service** **Frequency:** Once **Priority:** Routine
Question(s):
Priority:
Reason for Consult?
Order?
Name of referring provider:
Enter call back number:
Reason for Consult?
Process Instructions:
Note: Please call Palliative care office 832-522-8391. Due to current resource constraints, consultation orders received after 2:00 pm M-F will be seen the following business day. Consults placed over weekend will be seen on Monday.

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

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

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

☐ **Need time to evaluate patient for Code Status** **Frequency:** Once **Priority:** Routine

Isolation

☐ **Airborne isolation status**

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

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

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

☐ **Contact isolation status** **Frequency:** Continuous **Priority:** Routine

☐ **Droplet isolation status** **Frequency:** Continuous **Priority:** Routine

☐ **Enteric isolation status** **Frequency:** Continuous **Priority:** Routine

Precautions

☐ **Aspiration precautions** **Frequency:** Continuous **Priority:** Routine

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

☐ **Latex precautions** **Frequency:** Continuous **Priority:** Routine

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

Nursing

Vital signs

☑ **Vital signs - T/P/R/BP (per unit protocol)** **Frequency:** Per unit protocol **Priority:** Routine

Activity

☐ **Activity as tolerated** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Specify: ○ Activity as tolerated

☐ **Bed rest with bathroom privileges** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Bathroom Privileges: ○ with bathroom privileges

☐ **Out of bed, sit in chair (with assistance)** **Frequency:** 2 times daily **Start Date:** S **Priority:** Routine
Question(s):
Specify: ○ Activity as tolerated ○ Up with assistance

☐ **Out of bed, in chair and ambulate** **Frequency:** 2 times daily **Priority:** Routine
Question(s):
Specify: ○ Activity as tolerated ○ Up with assistance ○ Out of bed ○ Up in chair

☐ **Out of bed, encourage independent ambulation** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Specify: ○ Activity as tolerated ○ Out of bed

☐ **Weight bearing restrictions** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Weight Bearing Status:
Extremity:

☐ **Strict bed rest** **Frequency:** Until discontinued **Priority:** Routine

☐ **Up ad lib** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Specify: ○ Up ad lib

Nursing Care

☐ **Daily weights** **Frequency:** Daily **Priority:** Routine

☐ **Intake and Output Qshift** **Frequency:** Every shift **Priority:** Routine

☐ **Nasogastric tube insert and maintain**

☑ **Nasogastric tube insertion** **Frequency:** Once **Priority:** Routine
Question(s):
Type:

☐ **Nasogastric tube maintenance** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Tube Care Orders:

☐ **Insert and maintain Foley**

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

☑ **Insert Foley catheter** **Frequency:** Once **Priority:** Routine
Question(s):
Type:
Size:
Urinometer needed:
Indication:
Primary Ordering Comments:
Foley catheter may be removed per nursing protocol.

☑ **Foley Catheter Care** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Orders: Maintain

Notify Physician

☑ **Notify Physician(vitals,output,pulse ox)** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Temperature greater than: 100.5
Systolic BP greater than: 160
Systolic BP less than: 90
Diastolic BP greater than: 100
Diastolic BP less than: 50
Heart rate greater than (BPM): 100
Heart rate less than (BPM): 60
Respiratory rate greater than: 25
Respiratory rate less than: 8
SpO2 less than: 92
Temperature less than:
MAP less than: 60.000

Notify Physician- UTS

☐ **Notify Physician- Teaching Service** **Frequency:** Until discontinued **Priority:** Routine **Comments:** To reach the team taking care of this patient please call the University Teaching Service Answering Service at (713) 363-9648 and ask for the team taking care of the patient to be paged. The team name is listed in both "Treatment Teams" and "Notes from Clinical Staff" sections in the Summary\Overview tab of Epic. If no response, page the Sr. Resident at 713- 768-0403. If no response is obtained using second pager, page the attending assigned to the patient.

Diet

○ **NPO** **Frequency:** Diet effective now **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.

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

Tube Feed

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

☐ **Tube feeding - Continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Tube Feeding Schedule: ○ Continuous
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Schedule:
Dietitian to manage Tube Feed?

☐ **Tube feeding - Bolus** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
Tube Feeding Schedule: ○ Bolus
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Schedule:
Dietitian to manage Tube Feed?

☐ **Tube feeding - Cyclic** **Frequency:** Cyclic **Priority:** Routine
Question(s):
Tube Feeding Schedule: ○ Cyclic
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Formula:
Tube Feeding Schedule:
Dietitian to manage Tube Feed?

IV Fluids

Peripheral IV Access

☑ **Initiate and maintain IV**

☑ **Insert peripheral IV** **Frequency:** Once **Priority:** Routine

☑ **sodium chloride 0.9 % flush** **Dose:** 10 mL **Frequency:** every 12 hours scheduled **PRN Reasons:** line care

☑ **sodium chloride 0.9 % flush** **Dose:** 10 mL **Route:** intravenous **Frequency:** PRN **PRN Reasons:** line care

IV Bolus

○ **electrolyte-A (PLASMA-LYTE A) bolus** **Dose:** 500 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences

○ **electrolyte-A (PLASMA-LYTE A) bolus** **Dose:** 1000 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences

○ **albumin human 5 % bottle** **Dose:** 12.5 g **Route:** intravenous **Frequency:** once **Minimum Infusion Duration:** 15.000 Minutes
Question(s):
Indication:

○ **albumin human 5 % bottle** **Dose:** 25 g **Route:** intravenous **Frequency:** once **Minimum Infusion Duration:** 30.000 Minutes
Question(s):
Indication:

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

○ **sodium chloride 0.9 % bolus 500 mL Dose:** 500 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 15.000 Minutes

○ **sodium chloride 0.9 % bolus 1000 mL Dose:** 1000 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes

○ **sodium bicarbonate 150 mEq in sterile water 1,000 mL infusion Dose:** 1000 mL **Route:** intravenous **Frequency:** once **Minimum Infusion Duration:** 30.000 Minutes

○ **lactated ringer's bolus 500 mL Dose:** 500 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 15.000 Minutes

○ **lactated ringers bolus 1000 mL Dose:** 1000 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes

Maintenance IV Fluids

○ **sodium chloride 0.9 % infusion Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous

○ **lactated ringer's infusion Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous

○ **dextrose 5 % and sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous

○ **sodium chloride 0.45 % infusion Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous

○ **sodium chloride 0.45 % 1,000 mL with sodium bicarbonate 75 mEq/L infusion Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous

Medications

For Analgesics, please refer to the General Pain Management order sets.
For Antihypertensives, please refer to the Hypertensive Urgency order set.

Antibiotics

☐ **azithromycin (ZITHROMAX) IV Route:** intravenous **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication:
Product Admin Instructions:
May cause QTc prolongation.

☐ **azithromycin (ZITHROMAX) tablet Dose:** 250 **Route:** oral **Frequency:** daily
Question(s):
Indication:
Product Admin Instructions:
May cause QTc prolongation.

☐ **cefepime (MAXIPIME) IV Route:** intravenous **Frequency:** every 8 hours **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:
EXTENDED INFUSION Administer over 3 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

☐ **ceftriaxone (ROCEPHIN) IV Route:** intravenous **Priority:** STAT
Question(s):
Indication:
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

☐ **ciprofloxacin (CIPRO) IV Route:** intravenous **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Product Admin Instructions:
May cause QTc prolongation.

☐ **ciprofloxacin (CIPRO) tablet Dose:** 500 **Frequency:** 2 times daily at 0600, 1600
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
May cause QTc prolongation.
Product Admin Instructions:
If administering with tube feeds, mix with water to avoid interaction with tube feed

☐ **levofloxacin (LEVAQUIN) IV Route:** intravenous **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication:
Product Admin Instructions:
May cause QTc prolongation.

☐ **levofloxacin (LEVAQUIN) tablet Dose:** 250 **Route:** oral **Frequency:** daily at 0600
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
If administering with tube feeds, mix with water to avoid interaction with tube feed
Product Admin Instructions:
May cause QTc prolongation. Separate by 2 hours from any milk product, antacid, or iron.

☐ **meropenem (MERREM) IV Frequency:** every 8 hours **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:
EXTENDED INFUSION Administer over 3 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

☐ **metroNIDAZOLE (FLAGYL) IV Route:** intravenous **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication:

☐ **metroNIDAZOLE (FLAGYL) tablet Dose:** 250 **Route:** oral **Frequency:** 3 times daily
Question(s):
Indication:

☐ **piperacillin-tazobactam (ZOSYN) IV Route:** intravenous **Frequency:** every 8 hours **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:
EXTENDED INFUSION Administer over 4 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

☐ **vancomycin (VANCOCIN) IV + Pharmacy Consult to Dose** (Required)

☑ **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.

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

☐ **vancomycin (FIRVANQ) 50 mg/mL oral solution** **Dose:** 125 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Comment:** for Cdiff
Question(s):
Indication:
Admin Instructions:
KEEP REFRIGERATED. SHAKE WELL

Antipyretics

○ **ibuprofen tablet** **Dose:** 600 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Comment:** Fever GREATER than 100.5 F
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **acetaminophen (TYLENOL) tablet** **Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Comment:** Fever GREATER than 100.5 F **PRN Reasons:** fever
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

Shortness of Breath

☐ **albuterol (PROVENTIL) nebulizer solution** **Dose:** 2.5 mg **Route:** nebulization **Frequency:** Respiratory Therapy - every 4 hours
Question(s):
Aerosol Delivery Device:

☐ **albuterol (PROVENTIL) nebulizer solution** **Dose:** 2.5 mg **Route:** nebulization **Frequency:** every 4 hours PRN **PRN Reasons:** shortness of breath
Question(s):
Aerosol Delivery Device:

☐ **ipratropium (ATROVENT) 0.02 % nebulizer solution** **Dose:** 0.5 mg **Route:** nebulization **Frequency:** Respiratory Therapy - every 4 hours
Question(s):
Aerosol Delivery Device:

☐ **ipratropium (ATROVENT) 0.02 % nebulizer solution** **Dose:** 0.5 mg **Route:** nebulization **Frequency:** every 4 hours PRN **PRN Reasons:** shortness of breath
Question(s):
Aerosol Delivery Device:

☐ **ipratropium-albuteroL (DUO-NEB) 0.5-2.5 mg/3 mL nebulizer solution** **Dose:** 3 mL **Route:** nebulization **Frequency:** Respiratory Therapy - every 4 hours
Question(s):
Aerosol Delivery Device:

☐ **ipratropium-albuteroL (DUO-NEB) 0.5-2.5 mg/3 mL nebulizer solution** **Dose:** 3 mL **Route:** nebulization **Frequency:** every 4 hours PRN **PRN Reasons:** shortness of breath
Question(s):
Aerosol Delivery Device:

PRN Blood Pressure Agents

○ **hydrALAZINE (APRESOLINE) injection** **Dose:** 10 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Comment:** SBP GREATER than 180 mmHg **PRN Reasons:** high blood pressure
Question(s):
BP HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
May be given IN ADDITION TO scheduled doses if needed.

○ **enalaprilat (VASOTEC) injection** **Dose:** 1.25 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Comment:** SBP GREATER than 180 mmHg **PRN Reasons:** high blood pressure
Question(s):
BP HOLD parameters for this order: ○ ONCE or PRN Orders - No Hold Parameters Needed
Contact Physician if:

Beta-Blockers

○ **carvedilol (COREG) tablet Dose:** 6.25 mg **Route:** oral **Frequency:** 2 times daily
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
HOLD if systolic blood pressure is LESS THAN 90 millimeters of mercury OR if heart rate is EQUAL TO OR LESS THAN 55 beats per minute. Notify physician if medication is held. Give beta blockers with food and at least 2 hours apart from ACE Inhibitor or Angiotensin Receptor Blocker medication.

○ **metoprolol succinate XL (TOPROL-XL) 24 hr tablet Dose:** 25 mg **Route:** oral **Frequency:** daily
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
HOLD if systolic blood pressure is LESS THAN 90 millimeters of mercury OR if heart rate is EQUAL TO OR LESS THAN 55 beats per minute. Notify physician if medication is held. Give beta blockers with food and at least 2 hours apart from ACE Inhibitor or Angiotensin Receptor Blocker medication.
Product Admin Instructions:
Do not crush or chew.

○ **metoprolol tartrate (LOPRESSOR) tablet Dose:** 25 mg **Route:** oral **Frequency:** 2 times daily
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
HOLD if systolic blood pressure is LESS THAN 90 millimeters of mercury OR if heart rate is EQUAL TO OR LESS THAN 55 beats per minute. Notify physician if medication is held. Give beta blockers with food and at least 2 hours apart from ACE Inhibitor or Angiotensin Receptor Blocker medication.

Loop Diuretics

○ **furosemide (LASIX) 20 mg injection Dose:** 20 mg **Route:** intravenous **Frequency:** 2 times daily at 0900, 1700

○ **furosemide (LASIX) infusion Route:** intravenous **Frequency:** continuous

○ **bumetanide (BUMEX) 0.5 mg injection Dose:** 0.5 mg **Route:** intravenous **Frequency:** 2 times daily at 0900, 1700
Admin Instructions:
Max dose 10 mg/day

Non-Loop Diuretics

☐ **spironolactone (ALDACTONE) tablet Dose:** 25 mg **Route:** oral **Frequency:** daily
Question(s):
BP HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Nurse to check current serum Potassium level prior to Administration. Call MD if Potassium is greater than 5. HOLD DOSE FOR POTASSIUM LEVELS GREATER THAN 5. Avoid salt substitutes unless approved by MD.
Product Admin Instructions:
Hazardous medication – if needing crushed, request from pharmacy

☐ **eplerenone (INSPRA) tablet Dose:** 25 mg **Route:** oral **Frequency:** daily
Admin Instructions:
Nurse to check current serum Potassium level prior to Administration. Call MD if Potassium is greater than 5. HOLD DOSE FOR POTASSIUM LEVELS GREATER THAN 5. Avoid salt substitutes unless approved by MD.

☐ **metolazone (ZAROXOLYN) tablet Dose:** 5 mg **Route:** oral **Frequency:** daily

Nitrates

☐ **nitroglycerin (NITROSTAT) SL tablet Dose:** 0.4 mg **Route:** sublingual **Frequency:** every 5 min PRN **Frequency Limit:** 3 Occurrences **PRN Reasons:** chest pain
Admin Instructions:
Contact physician if given.

☐ **isosorbide mononitrate (MONOKET) tablet Dose:** 20 **Route:** oral **Frequency:** 2 times daily
Question(s):
BP HOLD parameters for this order:
Contact Physician if:

☐ **nitroglycerin (NITROSTAT) 2 % ointment Dose:** 0.5 inch **Route:** Topical **Frequency:** every 6 hours scheduled

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

☐ **nitroglycerin patch Dose:** 0.2 mg **Route:** transdermal **Frequency:** daily
Admin Instructions:
Remove before bedtime

☐ **isosorbide mononitrate (IMDUR) 24 hr tablet Dose:** 60 mg **Route:** oral **Frequency:** daily
Question(s):
BP HOLD parameters for this order:
Contact Physician if:
Product Admin Instructions:
Do not crush or chew.

☐ **isosorbide dinitrate (ISORDIL) tablet Dose:** 20 mg **Route:** oral **Frequency:** 3 times daily at 0900, 1300, 1700
Question(s):
BP HOLD parameters for this order:
Contact Physician if:

☐ **nitroglycerin (TRIDIL) 200 mcg/mL in sodium chloride 0.9% 250 mL infusion Dose:** 5 mcg/min **Frequency:** continuous
Admin Instructions:
HOLD if systolic blood pressure is LESS THAN 100 millimeters of mercury OR heart rate is LESS than 55 beats per minute.

Platelet Inhibitors

☐ **aspirin chewable 81 mg tablet Dose:** 81 mg **Route:** oral **Frequency:** daily

☐ **prasugrel (EFFIENT) tablet** (Required)

☑ **prasugrel (EFFIENT) tablet Dose:** 5 **Route:** oral **Frequency:** daily
Question(s):
Does this patient have a history of transient ischemic attack (TIA) or stroke?
Is the patient's age 75 years or older?
Is the patient's weight less than 60 kilograms?

☐ **ticagrelor (BRILINTA) tablet Dose:** 90 mg **Route:** oral **Frequency:** 2 times daily
Question(s):
Does the patient have active or a history of pathological bleeding (e.g., peptic ulcer or intracranial hemorrhage)?
Is the patient receiving maintenance aspirin dose greater than 100 mg/day?

☐ **clopidogrel (PLAVIX) 75 mg tablet Dose:** 75 mg **Route:** oral **Frequency:** daily

Miscellaneous Agents

☐ **hydralazine 10 mg / isosorbide dinitrate 10 mg (BIDIL)**

☑ **hydrALAZINE (APRESOLINE) tablet Dose:** 10 mg **Route:** oral **Frequency:** 3 times daily
Question(s):
BP HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
To be taken with isosorbide dinitrate 10 mg oral tablet

☑ **isosorbide dinitrate (ISORDIL) tablet Dose:** 10 mg **Route:** oral **Frequency:** 3 times daily at 0900, 1300, 1700
Question(s):
BP HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
To be taken with hydralazine 10 mg oral tablet

Cough

○ **guaiFENesin (MUCINEX) 12 hr tablet Dose:** 600 mg **Route:** oral **Frequency:** 2 times daily PRN **PRN Reasons:** cough

○ **dextromethorphan-guaifenesin (MUCINEX DM REGULAR) 30-600 mg per 12 hr tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 12 hours PRN **PRN Reasons:** cough
Admin Instructions:
Maximum: 4 tablets/24 hours
Product Admin Instructions:
maximum: 4 tablets/24 hours

○ **guaiFENesin (ROBITUSSIN) 100 mg/5 mL syrup Dose:** 100 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Reasons:** cough

○ **dextromethorphan-guaifenesin (ROBITUSSIN-DM) 10-100 mg/5 mL liquid Dose:** 5 mL **Route:** oral **Frequency:** every 4 hours PRN **PRN Reasons:** cough

○ **codeine-guaifenesin (GUAIFENESIN AC) 10-100 mg/5 mL liquid Dose:** 5 mL **Route:** oral **Frequency:** every 4 hours PRN **PRN Reasons:** cough

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

○ **benzonatate (TESSALON) capsule Dose:** 100 mg **Frequency:** every 6 hours PRN **PRN Reasons:** cough

HM IP MEDICATIONS - ADMISSION MEDICINE - CONSTIPATION FIRST LINE

○ **polyethylene glycol (MIRALAX) packet 17 gram Dose:** 17 g **Route:** oral **Frequency:** daily PRN **PRN Reasons:** constipation
Admin Instructions:
Use as first line option for constipation.
Product Admin Instructions:
Mix in 4-8oz of water.

○ **docusate sodium (COLACE) capsule Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily PRN **PRN Reasons:** constipation
Admin Instructions:
Use as first line option for constipation.

○ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** daily PRN **PRN Reasons:** constipation
Admin Instructions:
Use as first line option for constipation.

○ **bisacodyL (DULCOLAX) suppository Dose:** 10 mg **Route:** rectal **Frequency:** daily PRN **PRN Reasons:** constipation
Admin Instructions:
Use as first line option for constipation.

HM IP MEDICATIONS - ADMISSION MEDICINE - CONSTIPATION SECOND LINE

○ **polyethylene glycol (MIRALAX) packet 17 gram Dose:** 17 g **Route:** oral **Frequency:** daily PRN **PRN Reasons:** constipation
Admin Instructions:
Use as second line option if constipation unrelieved by first line option.
Product Admin Instructions:
Mix in 4-8oz of water.

○ **docusate sodium (COLACE) capsule Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily PRN **PRN Reasons:** constipation
Admin Instructions:
Use as second line option if constipation unrelieved by first line option.

○ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** daily PRN **PRN Reasons:** constipation
Admin Instructions:
Use as second line option if constipation unrelieved by first line option.

○ **bisacodyL (DULCOLAX) suppository Dose:** 10 mg **Route:** rectal **Frequency:** daily PRN **PRN Reasons:** constipation
Admin Instructions:
Use as second line option if constipation unrelieved by first line option.

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

Insomnia: For Patients GREATER than or EQUAL to 70 years old

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

Antiemetics

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

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

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

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

☐ **promethazine (PHENERGAN)**

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

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

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

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

Antiemetics

☑ **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.

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

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

Antiemetics

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

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

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

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

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

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

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

Itching: For Patients GREATER than 70 years old

◉ **cetirizine (ZyrTEC) tablet Dose:** 5 mg **Route:** oral **Frequency:** daily PRN **PRN Reasons:** itching

Itching: For Patients LESS than 70 years old

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

○ **hydrOXYzine (ATARAX) tablet Dose:** 10 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** itching

◉ **cetirizine (ZyrTEC) tablet Dose:** 5 mg **Route:** oral **Frequency:** daily PRN **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 **PRN Reasons:** itching

GI Drugs

☐ **famotidine (PEPCID) IV or ORAL**

◉ **famotidine (PEPCID) injection Dose:** 20 mg **Route:** intravenous **Frequency:** 2 times daily **Minimum Volume:** 2.000 mL
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication(s) for H2 Receptor Antagonist (H2RA) Therapy:
Admin Instructions:
IV or ORAL

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

◉ **famotidine (PEPCID) tablet Dose:** 20 mg **Route:** oral **Frequency:** 2 times daily
Question(s):
Indication(s) for H2 Receptor Antagonist (H2RA) Therapy:
Admin Instructions:
IV or ORAL

☐ **pantoprazole (PROTONIX) IV or Oral or Tube**

◉ **pantoprazole (PROTONIX) EC tablet Dose:** 40 mg **Route:** oral **Frequency:** daily at 0600
Question(s):
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
Give if patient is able to swallow

◉ **pantoprazole (PROTONIX) 40 mg in sodium chloride 0.9 % 10 mL injection Dose:** 40 mg **Route:** intravenous **Frequency:** daily at 0600
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
Give if patient is unable to tolerate oral medication

◉ **pantoprazole (PROTONIX) suspension Dose:** 40 mg **Route:** feeding tube **Frequency:** daily at 0600
Question(s):
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
Give if patient is unable to swallow

☐ **omeprazole (PriLOSEC) suspension Dose:** 2 **Frequency:** daily at 0600
Question(s):
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
Separate administration with all other oral medications by 1 hour.

☐ **sucralfate (CARAFATE) Oral or NG Tube**

◉ **sucralfate (CARAFATE) tablet - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER Dose:** 1 g **Route:** oral **Frequency:** 4 times daily with meals and nightly
Product Admin Instructions:
Take 1 hour before or 2 hours after meals**if ordered by Feeding tube Or PEG tube feeding should be stopped 1 hour before AND 1 hour after each dose.

◉ **sucralfate (CARAFATE) 100 mg/mL suspension - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER Dose:** 1 g **Route:** Nasogastric **Frequency:** 4 times daily with meals and nightly
Admin Instructions:
Use with Nasogastric tubing. Use if patient is unable to swallow tablet.
Product Admin Instructions:
Take 1 hour before or 2 hours after meals**if ordered by Feeding tube Or PEG tube feeding should be stopped 1 hour before AND 1 hour after each dose.

☐ **alum-mag hydroxide-simeth (MAALOX) 200-200-20 mg/5 mL suspension - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER Dose:** 30 mL **Route:** oral **Frequency:** every 4 hours PRN **PRN Reasons:** indigestion
Admin Instructions:
Do not give if patient is on hemodialysis or in chronic renal failure.

☐ **simethicone (MYLICON) chewable tablet Dose:** 80 mg **Route:** oral **Frequency:** every 4 hours PRN **Frequency Limit:** 2 Occurrences **PRN Reasons:** flatulence

GI Drugs

☐ **famotidine (PEPCID) IV or ORAL**

◉ **famotidine (PEPCID) injection Dose:** 20 mg **Route:** intravenous **Frequency:** 2 times daily **Minimum Volume:** 2.000 mL
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication(s) for H2 Receptor Antagonist (H2RA) Therapy:
Admin Instructions:
IV or ORAL

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

◉ **famotidine (PEPCID) tablet Dose:** 20 mg **Route:** oral **Frequency:** 2 times daily
Question(s):
Indication(s) for H2 Receptor Antagonist (H2RA) Therapy:
Admin Instructions:
IV or ORAL

☐ **pantoprazole (PROTONIX) IV or Oral or Tube**

◉ **pantoprazole (PROTONIX) EC tablet Dose:** 40 mg **Route:** oral **Frequency:** daily at 0600
Question(s):
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
Give if patient is able to swallow

◉ **pantoprazole (PROTONIX) 40 mg in sodium chloride 0.9 % 10 mL injection Dose:** 40 mg **Route:** intravenous **Frequency:** daily at 0600
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
Give if patient is unable to tolerate oral medication

◉ **pantoprazole (PROTONIX) suspension Dose:** 40 mg **Route:** feeding tube **Frequency:** daily at 0600
Question(s):
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
Give if patient is unable to swallow

☐ **sucralfate (CARAFATE) Oral or NG Tube**

◉ **sucralfate (CARAFATE) tablet - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER Dose:** 1 g **Route:** oral **Frequency:** 4 times daily with meals and nightly
Product Admin Instructions:
Take 1 hour before or 2 hours after meals**if ordered by Feeding tube Or PEG tube feeding should be stopped 1 hour before AND 1 hour after each dose.

◉ **sucralfate (CARAFATE) 100 mg/mL suspension - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER Dose:** 1 g **Route:** Nasogastric **Frequency:** 4 times daily with meals and nightly
Admin Instructions:
Use with Nasogastric tubing. Use if patient is unable to swallow tablet.
Product Admin Instructions:
Take 1 hour before or 2 hours after meals**if ordered by Feeding tube Or PEG tube feeding should be stopped 1 hour before AND 1 hour after each dose.

☐ **alum-mag hydroxide-simeth (MAALOX) 200-200-20 mg/5 mL suspension - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER Dose:** 30 mL **Route:** oral **Frequency:** every 4 hours PRN **PRN Reasons:** indigestion
Admin Instructions:
Do not give if patient is on hemodialysis or in chronic renal failure.

☐ **simethicone (MYLICON) chewable tablet Dose:** 80 mg **Route:** oral **Frequency:** every 4 hours PRN **Frequency Limit:** 2 Occurrences **PRN Reasons:** flatulence

☐ **sodium chloride 0.9% bag for line care**

☑ **sodium chloride 0.9 % bag for line care Dose:** .9 **Frequency:** PRN **PRN Reasons:** line care
Admin Instructions:
For flushing of extension tubing sets after administration of intermittent infusions. Program sodium chloride bag to run at the same infusion rate as medication given for a total volume equal to contents of tubing sets used. Change bag every 24 hours.

VTE

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

VTE Risk and Prophylaxis Tool (Required)

Low Risk Definition	**Moderate Risk Definition** Pharmacologic prophylaxis must be addressed. Mechanical prophylaxis is optional unless pharmacologic is contraindicated.	**High Risk Definition** Both pharmacologic AND mechanical prophylaxis must be addressed.
Age less than 60 years and NO other VTE risk factors	**One or more** of the following **medical conditions**:	**One or more** of the following **medical conditions**:
Patient already adequately anticoagulated	CHF, MI, lung disease, pneumonia, active inflammation, dehydration, varicose veins, cancer, sepsis, obesity, previous stroke, rheumatologic disease, sickle cell disease, leg swelling, ulcers, venous stasis and nephrotic syndrome	Thrombophilia (Factor V Leiden, prothrombin variant mutations, anticardiolipin antibody syndrome; antithrombin, protein C or protein S deficiency; hyperhomocysteinemia; myeloproliferative disorders)
	Age 60 and above	Severe fracture of hip, pelvis or leg
	Central line	Acute spinal cord injury with paresis
	History of DVT or family history of VTE	Multiple major traumas
	Anticipated length of stay GREATER than 48 hours	Abdominal or pelvic surgery for CANCER
	Less than fully and independently ambulatory	Acute ischemic stroke
	Estrogen therapy	History of PE
	Moderate or major surgery (not for cancer)	
	Major surgery within 3 months of admission	

Anticoagulation Guide for COVID patients (https://formweb.com/files/houstonmethodist/documents/COVID-19 Anticoagulation Guideline - 8.20.2021v15.pdf)

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

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

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

☑ **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
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)**

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

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

○ **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 Pharmacological Prophylaxis - Non-Surgical Patient** (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.

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

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)**

○ **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 **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
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

○ **aspirin (ECOTRIN) enteric coated tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1

○ **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
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
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)**

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

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

○ **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:

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** (Required)

Address both pharmacologic and mechanical prophylaxis by ordering from Pharmacological and Mechanical Prophylaxis.

☑ **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 **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:

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
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.

○ **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:

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

○ **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:

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

Address both pharmacologic and mechanical prophylaxis by ordering from Pharmacological and Mechanical Prophylaxis.

☑ **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

○ **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.

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

○ **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)**

○ **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:

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

Address both pharmacologic and mechanical prophylaxis by ordering from Pharmacological and Mechanical Prophylaxis.

☑ **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):

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

○ **aspirin chewable tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1

○ **aspirin (ECOTRIN) enteric coated tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1

○ **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:

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
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**

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

High Risk Bleeding Characteristics
Age ≥ 75
Weight < 50 kg
Unstable Hgb
Renal impairment
Plt count < 100 K/uL
Dual antiplatelet therapy
Active cancer
Cirrhosis/hepatic failure
Prior intra-cranial hemorrhage
Prior ischemic stroke
History of bleeding event requiring admission and/or transfusion
Chronic use of NSAIDs/steroids
Active GI ulcer

○ **High Bleed Risk**

Every 12 hour frequency is appropriate for most high bleeding risk patients. However, some high bleeding risk patients also have high clotting risk in which every 8 hour frequency may be clinically appropriate.

Please weight the risks/benefits of bleeding and clotting when selecting the dosing frequency.

○ **HEParin (porcine) injection - Q12 Hours 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:

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

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

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	

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

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)

☑ **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

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

☑ **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):

○ **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**

☑ **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
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):

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

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

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

○ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical** (Required)

Patient renal status: @CRCL@

For patients with CrCl GREATER than or EQUAL to 30mL/min, enoxaparin orders will apply the following recommended doses by weight:

Weight	Dose
LESS THAN 100kg	enoxaparin 40mg daily
100 to 139kg	enoxaparin 30mg every 12 hours
GREATER THAN or EQUAL to 140kg	enoxaparin 40mg every 12 hours

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection 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**

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

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)**

○ **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 **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
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

○ **aspirin (ECOTRIN) enteric coated tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1

○ **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
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 Today

☐ **CBC Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
CBC only; Does not include a differential

☐ **CBC and differential Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Prothrombin time with INR Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Partial thromboplastin time Frequency:** Once **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.

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

☐ **Anti Xa, unfractionated** **Frequency:** Once **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.

☐ **Sedimentation rate** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Chemistry Today

☐ **Albumin** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Amylase** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Basic metabolic panel** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **NT-proBNP** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **CK total** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Comprehensive metabolic panel** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hemoglobin A1c** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatic function panel** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lactic acid level - ONE TIME ORDER ONLY** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Process Instructions:
SEPSIS PATIENTS:

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

☐ **Lipase** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lipid panel** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Magnesium** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Phosphorus** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Prealbumin** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **TSH** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **T4, free** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Uric acid** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☐ **C-reactive protein** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Procalcitonin** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Cardiac

☐ **Troponin T : STAT** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Troponin T : Now and every 6 hours x 2** **Frequency:** Now then every 6 hours **Frequency Limit:** 2 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Troponin T : Now and every 8 hours x 2** **Frequency:** Now then every 8 hours **Frequency Limit:** 2 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Microbiology

☐ **Blood culture, aerobic and anaerobic x 2**

☑ **Blood culture, aerobic and anaerobic x 2**
Most recent Blood Culture results from the past 7 days:

@LASTPROCRESULT(LAB462)@

Blood Culture Best Practices (https://formweb.com/files/houstonmethodist/documents/blood-culture-stewardship.pdf)

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

☑ **Blood culture, aerobic & anaerobic** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Comments:** Collect before antibiotics given. Blood cultures should be drawn from a peripheral site. If unable to draw both sets from a peripheral site, please call the lab for assistance; an IV line should NEVER be used.

☑ **Blood culture, aerobic & anaerobic** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Comments:** Collect before antibiotics given. Blood cultures should be drawn from a peripheral site. If unable to draw both sets from a peripheral site, please call the lab for assistance; an IV line should NEVER be used.

☐ **Urinalysis screen and microscopy, with reflex to culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Urine
Comments: Not recommended for chronic Foley catheter patient or ESRD patient due to concerns of colonization
Question(s):
Specimen Source: Urine
Specimen Site:
Primary Ordering Comments:
Specimen must be received in the laboratory within 2 hours of collection.

☐ **Sputum culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Sputum

☐ **Respiratory Pathogen Panel with COVID-19** (Required)

☑ **Respiratory pathogen panel with COVID-19 RT-PCR** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nasopharyngeal

☑ **Isolation** (Required)
Airborne isolation is recommended for all Confirmed or Suspected COVID-19 patients.

☑ **Airborne Isolation**

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

☑ **Contact Isolation**

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

☐ **Influenza A and B, nucleic acid amplification**

☑ **Influenza A and B, nucleic acid amplification** **Frequency:** Once **Priority:** Routine
Question(s):
Specimen Source:

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

☐ **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**

☑ **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**

☑ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

☑ **MRSA PCR has been ordered within 24 hours. Repeat testing is not indicated at this time.**
@LASTLAB(MRSAPCR)@

☐ **MRSA PCR has been ordered within 24 hours. Repeat testing is not indicated at this time.** **Frequency:** Until discontinued **Priority:** Routine

☑ **MRSA PCR has been ordered within the last 7 days. This test has shown to retain high negative predictive value within this time interval.**
@LASTLAB(MRSAPCR)@

☐ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

☑ **This patient has a positive MRSA PCR result within the last 7 days.**
@LASTLAB(MRSAPCR)@

☐ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

☑ **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**
@LASTLAB(MRSAPCR)@

☑ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

Labs Tomorrow
Hematology/Coagulation Tomorrow

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

☐ **CBC** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
CBC only; Does not include a differential

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

☐ **Prothrombin time with INR** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Partial thromboplastin time** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **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.

☐ **Anti Xa, unfractionated** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **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 Tomorrow

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

☐ **Amylase** **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

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

☐ **CK total** **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

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

☐ **Lactic acid level - ONE TIME ORDER ONLY** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Process Instructions:
SEPSIS PATIENTS:

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

☐ **Lipase** **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

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

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

☐ **Prealbumin** **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

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

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

☐ **Urine drugs of abuse screen** **Frequency:** Once **Start Date:** S+1 **Priority:** Routine **Specimen Type:** Urine

Cardiology

Cardiology

☐ **Myocardial perfusion stress test** **Frequency:** 1 time imaging **Priority:** Routine **Comments:** Must order Stress Test ECG Only order in conjunction.
Question(s):
What stress agent will be used? ○ Regadenoson
Will this exam require to be scheduled as a one day or a two-day exam?
Patient's weight in pounds (lbs)?
Preferred interpreting Cardiologist or group:

☐ **Cv exercise treadmill stress (no imaging)** **Frequency:** Once **Priority:** Routine
Question(s):
What stress agent will be used? Regadenoson
This is a treadmill only exam, without imaging:

☐ **ECG 12 lead - Routine** **Frequency:** Once **Priority:** Routine **Maximum Quantity:** 6
Question(s):
Clinical Indications: ○ Chest Pain
Interpreting Physician:

☐ **ECG 12 lead - STAT** **Frequency:** Once **Priority:** STAT **Maximum Quantity:** 6
Question(s):
Clinical Indications: ○ Chest Pain
Interpreting Physician:

☐ **Echocardiogram complete w contrast and 3D if needed** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Does this study require a chemo toxicity strain protocol?
Does this exam need a strain protocol?
Call back number for Critical Findings:
Where should test be performed?
Does this exam need a bubble study?
Preferred interpreting Cardiologist or group:
Process Instructions:
If this patient has had an echocardiogram ordered/performed within the past 120 hours as indicated by repeat Echo orders report on the left. Please contact the Echo department at 713-441-2222 to discuss the reason for a repeat exam with a cardiologist.

For STAT order, select appropriate STAT Indication. Please enter the cell phone number for the ordering physician so the echo attending can communicate the results of the stat test promptly. If the phone number is not entered, we will not be able to perform the test as stat. Please note that nursing unit phone number or NP phone number do not meet this request'

Other Indications should be ordered for TODAY or Routine.

For Discharge or Observation patient, please choose TODAY as Priority.

Imaging

MRI/MRA

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

☐ **MRI Brain Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Special Brain protocol requested?
Is this scan to monitor for ARIA during an Alzheimer Therapy?
ARIA Alzheimer therapy:
What are the patient's sedation requirements?
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRI Brain W Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Special Brain protocol requested?
What are the patient's sedation requirements?
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRI Brain W Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Special Brain protocol requested?
What are the patient's sedation requirements?
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

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

☐ **MRA Head Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
What are the patient's sedation requirements?
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRA Head W Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
What are the patient's sedation requirements?
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRA Head W Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
What are the patient's sedation requirements?
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **MRA Neck Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
What are the patient's sedation requirements?
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

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

☐ **MRA Neck W Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
What are the patient's sedation requirements?
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRA Neck W Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
What are the patient's sedation requirements?
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

CT

☐ **CT Head Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Does this require fiducials?
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **CT Head W Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.
Does this require fiducials?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☐ **CT Head W Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☐ **CT Chest Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Protocol:
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☐ **CT Abdomen with IV and PO Contrast (Omnipaque)**
For those with iodine allergies, please order the panel with Readi-Cat (barium sulfate).

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

☑ **CT Abdomen W Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☑ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** **Dose:** 300 **Frequency:** once
Admin Instructions:
FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Omnipaque)**
For those with iodine allergies, please order the panel with Readi-Cat (barium sulfate).

☑ **CT Abdomen Pelvis Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☑ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** **Dose:** 300 **Frequency:** once
Admin Instructions:
FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Readi-Cat)**
Ordered as secondary option for those with iodine allergies.

☑ **CT Abdomen Pelvis Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☑ **barium (READI-CAT 2) 2.1 % (w/v), 2.0 % (w/w) suspension** **Dose:** 2 **Frequency:** once in imaging

☐ **CT Pelvis W Contrast (Omnipaque)**
For those with iodine allergies, please order the panel with Readi-Cat (barium sulfate).

☑ **CT Pelvis W Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☑ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** **Dose:** 300 **Frequency:** once
Admin Instructions:
FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Omnipaque)**
For those with iodine allergies, please order the panel with Readi-Cat (barium sulfate).

☑ **CT Abdomen Pelvis Wo Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

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

☑ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution Dose:** 300 **Frequency:** once
Admin Instructions:
FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Readi-Cat)**
Ordered as secondary option for those with iodine allergies.

☑ **CT Abdomen Pelvis Wo Contrast Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

Patients 60 years of age or diabetic will require a creatinine within one month of the CT appointment.

Patients taking metformin may be asked to hold their metformin following their procedure.

Patients who are breastfeeding may pump and discard the breast milk for 24 hours after their procedure, although this is not required.

Patients that are possibly pregnant may be required to have a pregnancy test or be asked to sign a waiver that they are not pregnant prior to their exam.

☑ **barium (READI-CAT 2) 2.1 % (w/v), 2.0 % (w/w) suspension Dose:** 2 **Frequency:** once in imaging

☐ **CT Sinus Wo Contrast Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

X-Ray

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

☐ **Chest 1 Vw Portable Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Chest 2 Vw Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Chest 2 Vw Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **KUB Kidney Ureter Bladder Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **KUB Kidney Ureter Bladder Frequency:** 1 time imaging **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Abdomen 2 Vw Ap W Upright And/Or Decubitus Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

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

☐ **Abdomen 2 Vw Ap W Upright And/Or Decubitus** **Frequency:** 1 time imaging **Priority:** STAT
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Ultrasound

☐ **US Abdomen Complete** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
NPO 8 hours before exam.

☐ **US Gallbladder** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
NPO 8 hours before exam.

☐ **US Renal** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the Ultrasound on a native kidney?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **US Pelvis Complete** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

☐ **US Pelvic Non Ob Limited** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

☐ **US Pelvic Transvaginal** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient to drink 32 ounces of water 45 minutes prior to exam. Do not empty bladder. Patient should have a full bladder.

☐ **Pv carotid duplex** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Laterality:
Special protocol:

☐ **Pv duplex arterial upper extremity** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Laterality:

☐ **Pv duplex arterial lower extremity** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Laterality:

☐ **Pv vascular screening** **Frequency:** 1 time imaging **Priority:** Routine

Other Studies

Respiratory

Respiratory

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

☐ **Oxygen therapy - NC 2 Lpm** **Frequency:** Continuous **Priority:** Routine
Question(s):
Initial Device: ○ Nasal Cannula
Device:
SpO2 Goal:
SpO2 Goal:
Titrate FiO2 to keep O2 saturations:
Notify Physician if:
Indications for O2 therapy:
Indications for O2 therapy:
Primary Ordering Comments:
@CERMSG(661071:25704)@

☐ **Incentive spirometry instructions** **Frequency:** Once **Priority:** Routine
Question(s):
Frequency of use:

Rehab

Consults

☐ **HM IP MEDICATIONS - ADMISSION MEDICINE - PHARMACY CONSULT PANEL**

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

☐ **Pharmacy Consult to Manage Heparin: STANDARD dose protocol (DVT/PE) - with titration boluses** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Heparin Indication:
Specify:
Specify:
Monitoring:
Process Instructions:
Standard Dose Protocol

- IF ORDERED, Initial Bolus (80 units/kg) with no maximum.
- Consider in patients at risk for recurrent embolization.
- Initial Infusion (18 units/kg/hr) with no maximum.
- More aggressive titration with additional bolus and increase in heparin for sub-therapeutic monitoring levels.

See protocol for details

☐ **Pharmacy consult to manage Heparin: LOW Dose protocol(ACS/Stroke/Afib)- withOUT titration boluses** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Heparin Indication:
Specify:
Monitoring: Anti-Xa
Process Instructions:
Low Dose Heparin Protocol

- IF ORDERED, Initial bolus (60 units/kg) up to a max of 5,000 units.
- Consider in patients at risk for bleeding.
- Initial infusion (12 units/kg/hr) up to a max of 1,000 units/hr initially.
- More conservative titration.

See protocol for details

Consult Pharmacy - Renal Dosing

☐ **Pharmacy consult to manage dose adjustments for renal function** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Adjust dose for:
Primary Ordering Comments:
Please assess for hemodialysis, peritoneal dialysis, or continuous renal replacement therapy (CRRT) orders in addition to creatine clearance when making dose adjustments.

Ancillary Consults

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

☐ **Consult to 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 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.

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

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

☐ **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?

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

☐ **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