Location: _____

General

Present on Admission (Required)

- ○ **COVID-19 virus detected** **Frequency:** Once **Priority:** Routine
- ○ **Suspected COVID-19 Virus** **Frequency:** Once **Priority:** Routine

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.

Code Status

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

- ☑ **Code Status**

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

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

Question(s):
Code Status decision reached by:

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

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

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

Question(s):
Priority:
Reason for Consult?
Order?
Name of referring provider:
Enter call back number:
Reason for Consult?

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

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

Question(s):
Reason for Consult:
Reason for Consult?

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

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

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

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

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

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

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

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

No negative pressure required

☑ **Airborne Isolation**

☑ **Airborne 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 (Required)
Vital signs with link to algorithm of Stepwise management of Hypoxemia

☑ **Vital signs - T/P/R/BP** **Frequency:** Per unit protocol **Frequency Limit:** -1 Days **Priority:** Routine

☑ **Pulse oximetry continuous** **Frequency:** Continuous **Frequency Limit:** -1 Days **Priority:** Routine
Question(s):
Current FIO2 or Room Air:

HM IP COVID-19 ICU NURSING CARE

☑ **Strict intake and output for a target of 24 hour NET EVEN balance** **Frequency:** Every hour **Priority:** Routine

☑ **Limit repeated entry to room** **Frequency:** Until discontinued **Frequency Limit:** -1 Occurrences **Priority:** Routine
Comments: Batch all care and work with pharmacy and providers to limit repeated entry to patient care room.

☑ **Oral care for intubated patients** **Frequency:** Every 4 hours **Priority:** Routine **Comments:** For intubated patients

☑ **Oral care for non intubated patients** **Frequency:** Every shift **Priority:** Routine **Comments:** For non intubated patients

☐ **Hemodynamic Monitoring** **Frequency:** Continuous **Priority:** Routine
Question(s):
Measure:

☐ **Measure central venous pressure** **Frequency:** Every 4 hours **Priority:** Routine

☐ **Telemetry**

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

☑ **Telemetry monitoring** **Frequency:** Continuous **Frequency Limit:** 48 Hours **Priority:** Routine
Question(s):
Order: Place in Centralized Telemetry Monitor: EKG Monitoring Only (Telemetry Box)
Reason for telemetry:
Can be off of Telemetry for baths? Yes
Can be off for transport and tests? Yes

☑ **Telemetry additional setup information** **Frequency:** Continuous **Frequency Limit:** 48 Hours **Priority:** Routine
Question(s):
High Heart Rate (BPM): 130.000
Low Heart Rate(BPM): 50.000
High PVC's (per minute): 10.000

☐ **Insert and Maintain Temperature Sensing Foley**

☑ **Insert Foley catheter** **Frequency:** Once **Priority:** Routine
Question(s):
Type: ○ Temperature Sensing
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

☐ **Neurological assessment** **Frequency:** Every shift **Priority:** Routine
Question(s):
Assessment to Perform:

☐ **Peripheral vascular assessment** **Frequency:** Every 6 hours **Priority:** Routine

☐ **Elevate HOB** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Head of bed: ○ 30 degrees

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

Activity (Required)

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

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

☐ **Up with assistance** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Specify: ○ Up with assistance

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

COVID-19 Position Care

☐ **ICU proning interventions** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indications for Proning:
BIS score 40 to 60 OR RASS - 4?

☐ **Return patient to supine post-proning** **Frequency:** Until discontinued **Priority:** Routine

HM IP NOTIFY COVID-19 ADMISSION

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

☑ **Notify Physician for vitals: Frequency:** Until discontinued **Priority:** Routine
Question(s):
MAP less than: ○ 65 ○ 60.000
Heart rate greater than (BPM): ○ 120 ○ 100
Heart rate less than (BPM): 60
SpO2 less than: 92
Temperature greater than: 100.5
Temperature less than:
Systolic BP greater than: 160
Systolic BP less than: 90
Diastolic BP greater than: 100
Diastolic BP less than: 50
Respiratory rate greater than: 25
Respiratory rate less than: 8

☑ **Notify Physician for any acute changes in patient conditions (mental status, RR, O2 requirement, or other vital sign changes) Frequency:** Until discontinued **Frequency Limit:** -1 Days **Priority:** Routine **Comments:** For critical values.

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.

○ **NPO - except meds Frequency:** Diet effective now **Priority:** Routine
Question(s):
NPO: ○ Except meds
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:

○ **Feeding tube**

☑ **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?

☑ **XR Abdomen 1 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.):

IV Fluids-IV Fluids for COVID-19 Should be Minimized
IV Fluids for COVID-19 Should be Minimized

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

Insert and Maintain IV / Central Line Access

☑ **Insert and Maintain IV**

☑ **Insert peripheral IV** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Ordering Quantity:** 1 **Priority:** STAT

☑ **Saline lock IV** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Ordering Quantity:** 1 **Priority:** Routine

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

☐ **Consult for Venous Access** **Frequency:** Once **Priority:** Routine
Question(s):
Access:
Reason for Consult?
Process Instructions:
For all venous access consults, nephrology consultation is recommended when GFR is less than 45.

Bolus Fluids

IV Fluids for COVID-19 Should be Minimized

○ **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

○ **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

○ **albumin human 5 % bottle** **Dose:** 25 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 15.000 Minutes
Question(s):
Indication:

Medications

Pharmacy Consults

☐ **Pharmacy consult to change IV medications to concentrate fluids maximally** **Frequency:** Until discontinued **Priority:** Routine

☐ **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.

General COVID-19 Treatment

Neither Azithromycin, Hydroxychloroquine nor Ivermectin (or any combination thereof) are viable treatments for COVID-19.
Use of these agents for the treatment of COVID-19 at HM shall be limited only to within the context of a clinical trial.

Contact local Clinical Pharmacy with any questions.

○ **Moderate to Severe COVID-19**

Houston Methodist has approved this drug with certain criteria based on those who are most likely to benefit from its use. Please review the following criteria for your patient:

SARS-CoV-2 PCR or Antigen result documented within 10 days
Documented symptom onset within 10 days
REQUIRING SUPPLEMENTAL OXYGEN to maintain SpO2 GREATER than 94% or an SpO2 LESS than or EQUAL to 94% on Room Air without improvement
ALT LESS than 10x the upper limit of normal

Patients may not benefit from remdesivir treatment if they are beyond 10 days from symptom onset

☑ **remdesivir IV Loading and Maintenance Doses - HMH Only**

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

☑ **remdesivir in sodium chloride 0.9% 100 mL infusion Dose:** 50 **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir in sodium chloride 0.9% 100 mL infusion Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1000 **Frequency Limit:** 4 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
NOTE: Patients do NOT need to complete a full course of Remdesivir prior to discharge.

☑ **remdesivir IV Loading and Maintenance Doses - HMSL Only**

☑ **remdesivir in sodium chloride 0.9% 100 mL infusion Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir in sodium chloride 0.9% 100 mL infusion Dose:** 100 mg **Route:** intravenous **Frequency:** every 24 hours **Frequency Limit:** 4 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
NOTE: Patients do NOT need to complete a full course of Remdesivir prior to discharge.

☑ **remdesivir IV Loading and Maintenance Doses - HMB Only**

☑ **remdesivir in sodium chloride 0.9% 250 mL infusion Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir in sodium chloride 0.9% 250 mL infusion Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1500 **Frequency Limit:** 4 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
NOTE: Patients do NOT need to complete a full course of Remdesivir prior to discharge.

☑ **remdesivir IV Loading and Maintenance Doses - HMTW Only**

☑ **remdesivir in sodium chloride 0.9% 100 mL infusion Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir in sodium chloride 0.9% 100 mL infusion Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1100 **Frequency Limit:** 4 Occurrences **Minimum Infusion Duration:** 60.000 Minutes
Admin Instructions:
NOTE: Patients do NOT need to complete a full course of Remdesivir prior to discharge.

☑ **remdesivir IV Loading and Maintenance Doses - HMCL Only**

☑ **remdesivir in sodium chloride 0.9% 250 mL infusion Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir in sodium chloride 0.9% 250 mL infusion Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1000 **Frequency Limit:** 4 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
NOTE: Patients do NOT need to complete a full course of Remdesivir prior to discharge.

☑ **remdesivir IV Loading and Maintenance Doses - HMWB Only**

☑ **remdesivir in sodium chloride 0.9% 250 mL infusion Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir in sodium chloride 0.9% 100 mL infusion Dose:** 100 mg **Route:** intravenous **Frequency:** nightly **Frequency Limit:** 4 Occurrences **Minimum Infusion Duration:** 60.000 Minutes
Admin Instructions:
NOTE: Patients do NOT need to complete a full course of Remdesivir prior to discharge.

☑ **remdesivir IV Loading and Maintenance Doses - HMW Only**

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

☑ **remdesivir in sodium chloride 0.9% 250 mL infusion** **Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir in sodium chloride 0.9% 250 mL infusion** **Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1000 **Frequency Limit:** 4 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
NOTE: Patients do NOT need to complete a full course of Remdesivir prior to discharge.

☑ **remdesivir IV Loading and Maintenance Doses - HMCCH Only**

☑ **remdesivir in sodium chloride 0.9% 250 mL infusion** **Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir in sodium chloride 0.9% 250 mL infusion** **Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1000 **Frequency Limit:** 4 Occurrences **Minimum Infusion Duration:** 30.000 Minutes
Admin Instructions:
NOTE: Patients do NOT need to complete a full course of Remdesivir prior to discharge.

○ **Mild COVID-19**

Houston Methodist has approved the use of a 3 day course of remdesivir in patients with mild COVID-19 not admitted to the hospital for COVID related symptoms
Please review the following criteria for your patient:

- **Patient was NOT hospitalized BECAUSE OF COVID-19 diagnosis and/or symptoms**

Patient is currently NOT REQUIRING OXYGEN (or increase in baseline oxygen requirement)
Patient has not received remdesivir in last 90 days
Patient is immunocompromised - OR - > 65 with at least one comorbid condition conferring high risk to progression

If patient was hospitalized BECAUSE OF COVID-19 AND REQUIRING OXYGEN, please see "Moderate to Severe COVID-19"

☑ **Mild - HMB Only**

☑ **remdesivir infusion** **Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir infusion** **Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1500 **Frequency Limit:** 2 Occurrences **Start Date:** S+1
Admin Instructions:
Hold for ALT greater than 500

☑ **Mild - HMH Only**

☑ **remdesivir infusion** **Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir infusion** **Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1100 **Frequency Limit:** 2 Occurrences **Start Date:** S+1
Admin Instructions:
Hold for ALT greater than 500

☑ **Mild - HMW Only**

☑ **remdesivir infusion** **Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir infusion** **Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1500 **Frequency Limit:** 2 Occurrences **Start Date:** S+1
Admin Instructions:
Hold for ALT greater than 500

☑ **Mild - HMWB Only**

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

☑ **remdesivir infusion** **Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir infusion** **Dose:** 100 mg **Route:** intravenous **Frequency:** nightly **Frequency Limit:** 2 Occurrences
Admin Instructions:
Hold for ALT greater than 500

☑ **Mild - HMSL Only**

☑ **remdesivir infusion** **Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir infusion** **Dose:** 100 mg **Route:** intravenous **Frequency:** every 24 hours **Frequency Limit:** 2 Occurrences **Start Date:** S+1
Admin Instructions:
Hold for ALT greater than 500

☑ **Mild - HMCL Only**

☑ **remdesivir infusion** **Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir infusion** **Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1300 **Frequency Limit:** 2 Occurrences **Start Date:** S+1
Admin Instructions:
Hold for ALT greater than 500

☑ **Mild - HMCCH Only**

☑ **remdesivir infusion** **Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir infusion** **Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1000 **Frequency Limit:** 2 Occurrences **Start Date:** S+1
Admin Instructions:
Hold for ALT greater than 500

☑ **Mild - HMTW Only**

☑ **remdesivir infusion** **Dose:** 200 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Minimum Infusion Duration: 30.000 Minutes
Admin Instructions:
Hold for ALT greater than 500

☑ **remdesivir infusion** **Dose:** 100 mg **Route:** intravenous **Frequency:** daily at 1100 **Frequency Limit:** 2 Occurrences **Minimum Infusion Duration:** 60.000 Minutes
Admin Instructions:
Hold for ALT greater than 500

☐ **Immunomodulatory Agents**

☐ **Baricitinib (OLUMIANT) for COVID-19 (RESTRICTED)**

☑ **baricitinib (OLUMIANT) tablet (RESTRICTED)** **Dose:** 4 mg **Route:** oral **Frequency:** daily at 1700 **Frequency Limit:** 14 Occurrences
Question(s):
RESTRICTED to infectious diseases, pulmonary, or critical care specialists. Are you a specialist or ordering on behalf of one?
The patient has PCR-confirmed SARS-CoV-2/COVID and is requiring Humidified High-Flow Oxygen (Airvo) support or invasive or non-invasive ventilation.:
Does the patient have a history of TB?
Does the patient have an active bacterial or fungal infection?
The patient has an ALC LESS than 200 or ANC LESS than 1000 or hemoglobin LESS than 8:
Is this patient on renal replacement therapy?
I am aware that baricitinib increases the risk for secondary bacterial and fungal infections.:
Admin Instructions:
May dissolve INTACT tablet in 20-30 mL of water for administration via feeding tube. DO NOT CRUSH.

☐ **QuantiFERON-TB Gold Plus, 4 tube** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine
Specimen Type: Blood **Maximum Quantity:** 3

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

☐ **Coccidioides antibody, IgG/IgM by ELISA** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

☐ **Histoplasma Abs** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

☐ **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.

☐ **tocilizumab-aazg (TYENNE) infusion for COVID (RESTRICTED)** **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
RESTRICTED to infectious diseases, pulmonary, or critical care specialists. Are you a specialist or ordering on behalf of one?
Is this a repeat dose?
Does the patient have a history of TB?
Does the patient have an active bacterial or fungal infection?
Does the patient have chronic bowel disease – risk of GI perforation?
I am aware that tocilizumab-aazg increases the risk for secondary bacterial and/or fungal infections.:

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.

☐ **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

☐ **linezolid (ZYVOX) IV** **Frequency:** every 12 hours **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:

☐ **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.

☐ **meropenem (MERREM) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 6 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:

☐ **Vancomycin IV**

○ **vancomycin (VANCOCIN) IV - for PERIPHERAL LINE USE ONLY Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:

○ **vancomycin (VANCOCIN) IV - for CENTRAL LINE USE ONLY Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
This medication must be given via central line, and this patient does not have a central line documented in Lines/Drains/Airway. Do you attest to the following:
Admin Instructions:
For CENTRAL LINE use only.
Product Admin Instructions:
For CENTRAL LINE use only.

Scheduled Antihypertensives

○ **labetalol (NORMODYNE) tablet Dose:** 100 **Route:** oral **Frequency:** 2 times daily
Question(s):
BP & HR HOLD parameters for this order: ○ BP & HR HOLD Parameters requested
BP & HR HOLD for: ○ Heart Rate LESS than 60 bpm ○ Systolic BP LESS than 100 mmHg
Contact Physician if:

○ **labetalol (NORMODYNE) Route:** intravenous **Frequency:** 2 times daily
Question(s):
BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested
BP & HR HOLD for: Other Systolic BP
Hold for Systolic BP LESS than (in mmHg): 110
Admin Instructions:
Administer if Systolic BP GREATER than ***

○ **metoprolol tartrate (LOPRESSOR) tablet Dose:** 100 **Route:** oral **Frequency:** 2 times daily
Question(s):
BP & HR HOLD parameters for this order: ○ BP & HR HOLD Parameters requested
BP & HR HOLD for: ○ Heart Rate LESS than 60 bpm ○ Systolic BP LESS than 100 mmHg
Contact Physician if:

○ **metoprolol (LOPRESSOR) injection Dose:** 5 **Route:** intravenous
Question(s):
BP & HR HOLD parameters for this order: ○ BP & HR HOLD Parameters requested
BP & HR HOLD for: ○ Heart Rate LESS than 60 bpm ○ Systolic BP LESS than 100 mmHg
Contact Physician if:
Admin Instructions:
Maximum total dose is 15 mg over a 10-15 minute period.

○ **hydrALAZINE (APRESOLINE) injection Dose:** 20 **Route:** intravenous **Frequency:** every 6 hours **PRN Reasons:** high blood pressure
Question(s):
BP HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Administer if Systolic BP GREATER than ***

PRN Antihypertensives

☐ **labetalol (NORMODYNE,TRANDATE) injection - Select an alternative agent if heart rate is LESS than 55 BPM Dose:** 10 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Comment:** Systolic Blood Pressure GREATER than 160 mmHg **PRN Reasons:** high blood pressure
Question(s):
BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested
BP & HR HOLD for: Other Heart Rate
Hold for Heart Rate LESS than (in bpm): 55
Admin Instructions:
Administer at 2 mg/minute.

☐ **hydrALAZINE (APRESOLINE) injection - Use alternative therapy if patient is tachycardic (GREATER than 100 BPM) Dose:** 10 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Comment:** Systolic Blood Pressure GREATER than 160 mmHg **PRN Reasons:** high blood pressure
Question(s):
Hold for Heart Rate GREATER than (in bpm): 100
BP HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Administer if Systolic BP GREATER than ***

Neuromuscular Blockade

Dose based on Ideal body weight (IBW), unless actual body weight LESS than ideal body weight.

○ **cisatracurium (NIMbex) Continuous Infusion**

Recommended for patients with renal or hepatic failure.

☑ **cisatracurium (NIMbex) infusion Dose:** 1 - 10 mcg/kg/min **Route:** intravenous **Frequency:** continuous
Admin Instructions:
PROGRAM INFUSION PUMP WITH WEIGHT NOTED IN ORDER MEDICATION DOSED BY IDEAL BODY WEIGHT

Initiate infusion at 1mcg/kg/min. Titrate by 0.5 mcg/kg/min every hour to achieve 2 of 4 Train of Four (TOF). Once at 2 of 4 TOF, repeat TOF in four hours. IF TOF GREATER than 2 of 4, INCREASE infusion rate by 0.5 mcg/kg/min. Monitor TOF every hour to achieve and maintain 2 of 4 TOF. Once at 2 of 4 TOF, repeat TOF in four hours. IF TOF 2 of 4, CONTINUE the same infusion rate, then repeat TOF in 4 hours. IF TOF LESS than 2 of 4, DECREASE infusion rate by 0.5 mcg/kg/min. Monitor TOF every hour to achieve and maintain 2 of 4 TOF. Once at 2 of 4 TOF, repeat TOF in four hours. Max dose 10mcg/kg/min.

○ **cisatracurium (NIMbex) IV Bolus and Continuous Infusion**

Recommended for patients with renal or hepatic failure.

☑ **cisatracurium (NIMbex) injection Dose:** 0.15 mg/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences

☑ **cisatracurium (NIMbex) infusion Dose:** 1 - 10 mcg/kg/min **Route:** intravenous **Frequency:** continuous
Admin Instructions:
PROGRAM INFUSION PUMP WITH WEIGHT NOTED IN ORDER MEDICATION DOSED BY IDEAL BODY WEIGHT

Initiate infusion at 1mcg/kg/min. Titrate by 0.5 mcg/kg/min every hour to achieve 2 of 4 Train of Four (TOF). Once at 2 of 4 TOF, repeat TOF in four hours. IF TOF GREATER than 2 of 4, INCREASE infusion rate by 0.5 mcg/kg/min. Monitor TOF every hour to achieve and maintain 2 of 4 TOF. Once at 2 of 4 TOF, repeat TOF in four hours. IF TOF 2 of 4, CONTINUE the same infusion rate, then repeat TOF in 4 hours. IF TOF LESS than 2 of 4, DECREASE infusion rate by 0.5 mcg/kg/min. Monitor TOF every hour to achieve and maintain 2 of 4 TOF. Once at 2 of 4 TOF, repeat TOF in four hours. Max dose 10mcg/kg/min.

○ **vercuronium (NORCURON) Continuous Infusion**

Use caution in patients with renal or hepatic dysfunction

☑ **vecuronium (NORCURON) 1 mg/mL in sodium chloride 0.9% 100 mL infusion Dose:** 0.8 - 1.5 mcg/kg/min **Route:** intravenous **Frequency:** continuous
Admin Instructions:
PROGRAM INFUSION PUMP WITH WEIGHT NOTED IN ORDER MEDICATION DOSED BY IDEAL BODY WEIGHT

Initiate infusion at 0.8mcg/kg/min. Titrate by 0.1 mcg/kg/min every hour to achieve 2 of 4 Train of Four (TOF). Once at 2 of 4 TOF, repeat TOF in four hours. IF TOF GREATER than 2/4, INCREASE infusion rate by 0.1 mcg/kg/min. Monitor TOF every hour to achieve and maintain 2 of 4 TOF. Once at 2 of 4 TOF, repeat TOF in four hours. IF TOF 2 of 4, CONTINUE the same infusion rate, then repeat TOF in 4 hours. IF TOF LESS than 2 of 4, DECREASE infusion rate by 0.1 mcg/kg/min. Monitor TOF every hour to achieve and maintain 2 of 4 TOF. Once at 2 of 4 TOF, repeat TOF in four hours. Max dose 1.5mcg/kg/min.

○ **vecuronium (NORCURON) IV Bolus and Continuous Infusion**

Use caution in patients with renal or hepatic dysfunction

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

☑ **vecuronium (NORCURON) in SWFI injection 1 mg/mL Dose:** 0.1 mg/kg **Route:** intravenous **Frequency:** once
Frequency Limit: 1 Occurrences
Admin Instructions:
Reconstitute vecuronium 10 mg vial with 10 mL of sterile water to make 1 mg/mL concentration. Reconstituted solution must be used within 1 hour

☑ **vecuronium (NORCURON) 1 mg/mL in sodium chloride 0.9% 100 mL infusion Dose:** 0.8 - 1.5 mcg/kg/min **Route:** intravenous **Frequency:** continuous
Admin Instructions:
PROGRAM INFUSION PUMP WITH WEIGHT NOTED IN ORDER MEDICATION DOSED BY IDEAL BODY WEIGHT

Initiate infusion at 0.8mcg/kg/min. Titrate by 0.1 mcg/kg/min every hour to achieve 2 of 4 Train of Four (TOF). Once at 2 of 4 TOF, repeat TOF in four hours. IF TOF GREATER than 2/4, INCREASE infusion rate by 0.1 mcg/kg/min. Monitor TOF every hour to achieve and maintain 2 of 4 TOF. Once at 2 of 4 TOF, repeat TOF in four hours. IF TOF 2 of 4, CONTINUE the same infusion rate, then repeat TOF in 4 hours. IF TOF LESS than 2 of 4, DECREASE infusion rate by 0.1 mcg/kg/min. Monitor TOF every hour to achieve and maintain 2 of 4 TOF. Once at 2 of 4 TOF, repeat TOF in four hours. Max dose 1.5mcg/kg/min.

☐ **Vasoactive Drips**

☐ **DOPamine IV infusion Frequency:** titrated **Priority:** STAT

☐ **DOButamine (DOBUTREX) infusion Dose:** 2 mcg/kg/min **Route:** intravenous **Frequency:** continuous **Priority:** STAT

☐ **epINEPHrine infusion Frequency:** titrated **Priority:** STAT

☐ **norEPInephrine (LEVOPHED) infusion Frequency:** titrated **Priority:** STAT

☐ **phenylephrine (NEO-SYNEPHRINE) infusion Frequency:** titrated **Priority:** STAT

☐ **vasopressin (VASOSTRICT) infusion for shock Dose:** 0.04 Units/min **Route:** intravenous **Frequency:** continuous **Priority:** STAT

☐ **milrinone infusion 200 mcg/mL (premixed) Dose:** 0.125 - 0.75 mcg/kg/min **Route:** intravenous **Frequency:** titrated
Admin Instructions:
Contact provider if arrhythmia occurs

☐ **nitroglycerin infusion Dose:** 5 - 200 mcg/min **Route:** intravenous **Frequency:** titrated

☐ **nitroprusside (NIPRIDE) infusion Dose:** 0.3 - 8 mcg/kg/min **Route:** intravenous **Frequency:** titrated

☐ **niCARDipine (CARDENE) IV infusion Frequency:** titrated

☐ **esmolol (BREVIBLOC) infusion Dose:** 50 - 200 mcg/kg/min **Route:** intravenous **Frequency:** titrated

Sedation

☐ **propofol (DIPRIVAN) or DEXMEDETomidine (PREcedex) infusion**

☐ **propofol (DIPRIVAN) infusion Dose:** 0 - 50 mcg/kg/min **Route:** intravenous **Frequency:** continuous
Question(s):
LESS than desired sedation effect: Other
Specify: INCREASE rate by 5 mcg/kg/min.
DESIRED sedation effect: Continue the same rate. Reassess sedation within 4 hours.
GREATER than desired sedation effect: DECREASE rate 5 mcg/kg/min while titrating sedation to meet RASS goal, Reassess RASS every 30 minutes
If patient requiring GREATER than: 50 mcg/kg/min, Contact MD to re-evaluate sedation therapy
Propofol continuous infusion is to be used only in intubated patients on mechanical ventilation. Is the patient intubated or pending intubation?
Admin Instructions:
Initiate propofol at 10 mcg/kg/min. After initiation reassess RASS/BIS within 10 min. Titrate for Sedation. No bolus doses unless instructed by provider. A separate "propofol bolus from bottle" order must be placed.

☐ **dexMEDEtomidine (PREcedex) infusion Dose:** 0.1 - 1.5 mcg/kg/hr **Route:** intravenous **Frequency:** continuous
Question(s):
LESS than desired sedation effect: INCREASE rate by 0.1 mcg/kg/hour.
GREATER than desired sedation effect: Other (Specify)
Specify: DECREASE rate by 0.1 mcg/kg/hour.
If patient requiring GREATER than: 1.5 mcg/kg/hr, Contact MD to re-evaluate sedation therapy
Admin Instructions:
Generally for mild to moderate sedation. Not for use in patients on neuromuscular blocking agents. NO LOADING DOSE. Initiate dexMEDEtomidine at 0.2 mcg/kg/hr. After initiation reassess RASS within 1 hour. Titrate for Sedation.

☐ **lorazepam (ATIVAN) or midazolam (VERSED) infusion - HMH, HMSL, HMTW, HMWB, HMCL**

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

○ **lorazepam (ATIVAN) 60 mg/30 mL infusion** **Dose:** 2 **Route:** intravenous **Frequency:** continuous
Question(s):
Indication(s): Sedation
Admin Instructions:
LESS than desired sedation effect: administer bolus and increase rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
DESIRED sedation effect: Continue the same rate. Reassess RASS/BIS within 4 hrs
GREATER than desired sedation effect: Decrease rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
If patient requires GREATER than 5mg/hr lorazepam, contact MD to re-evaluate sedation therapy
Maximum recommended dose 10 mg/hr

○ **midazolam (VERSED) 60 mg/30 mL infusion** **Dose:** 2 **Route:** intravenous **Frequency:** continuous
Question(s):
Indication(s): ○ Sedation
Midazolam continuous infusion is to be used only in intubated patients on mechanical ventilation. Is the patient intubated or pending intubation?
Admin Instructions:
LESS than desired sedation effect: administer bolus and increase rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
DESIRED sedation effect: Continue the same rate. Reassess RASS/BIS within 4 hrs
GREATER than desired sedation effect: Decrease rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
If patient requires GREATER than 5mg/hr midazolam, contact MD to re-evaluate sedation therapy
Maximum recommended dose 10 mg/hr

☐ **lorazepam (ATIVAN) or midazolam (VERSED) infusion - HMSJ HMSTC Only**

○ **LORAZepam (ATIVAN) 60 mg/30 mL infusion** **Dose:** 2 **Route:** intravenous **Frequency:** continuous
Question(s):
Indication(s): Sedation
Admin Instructions:
LESS than desired sedation effect: administer bolus and increase rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
DESIRED sedation effect: Continue the same rate. Reassess RASS/BIS within 4 hrs
GREATER than desired sedation effect: Decrease rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
If patient requires GREATER than 5mg/hr lorazepam, contact MD to re-evaluate sedation therapy
Maximum recommended dose 10 mg/hr

○ **MIDAZolam (VERSED) 30 mg/30 mL infusion** **Dose:** 1 **Route:** intravenous **Frequency:** continuous
Question(s):
Indication(s): ○ Sedation
Midazolam continuous infusion is to be used only in intubated patients on mechanical ventilation. Is the patient intubated or pending intubation?
Admin Instructions:
LESS than desired sedation effect: administer bolus and increase rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
DESIRED sedation effect: Continue the same rate. Reassess RASS/BIS within 4 hrs
GREATER than desired sedation effect: Decrease rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
If patient requires GREATER than 5mg/hr midazolam, contact MD to re-evaluate sedation therapy
Maximum recommended dose 10 mg/hr

☐ **lorazepam (ATIVAN) or midazolam (VERSED) infusion - HMW, HMCY Only**

○ **LORAZepam (ATIVAN) 30 mg/30 mL infusion** **Dose:** 1 **Route:** intravenous **Frequency:** continuous
Question(s):
Indication(s): Sedation
Admin Instructions:
LESS than desired sedation effect: administer bolus and increase rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
DESIRED sedation effect: Continue the same rate. Reassess RASS/BIS within 4 hrs
GREATER than desired sedation effect: Decrease rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
If patient requires GREATER than 5mg/hr lorazepam, contact MD to re-evaluate sedation therapy
Maximum recommended dose 10 mg/hr

○ **MIDAZolam in 0.9% NaCl (VERSED) 1 mg/mL infusion Dose:** 1 **Route:** intravenous **Frequency:** continuous
Question(s):
Indication(s):
Midazolam continuous infusion is to be used only in intubated patients on mechanical ventilation. Is the patient intubated or pending intubation?
Admin Instructions:
LESS than desired sedation effect: administer bolus and increase rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
DESIRED sedation effect: Continue the same rate. Reassess RASS/BIS within 4 hrs
GREATER than desired sedation effect: Decrease rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
If patient requires GREATER than 5mg/hr midazolam, contact MD to re-evaluate sedation therapy
Maximum recommended dose 10 mg/hr

☐ **fentanyl (SUBLIMAZE) or hydromorPHONE (DILAUDID) infusion - HMSJ Only**

○ **fentaNYL (SUBLIMAZE) 1500 mcg/30 mL infusion Dose:** 50 **Frequency:** continuous
Admin Instructions:
LESS than desired sedation effect: administer bolus and increase rate by 25mcg/hr then reassess RASS/BIS within 30 mins until at goal
DESIRED sedation effect: Continue the same rate. Reassess sedation within 4 hrs
GREATER than desired sedation effect: Decrease rate by 25 mcg/hr and reassess RASS/BIS within 30 mins until at goal
If patient requires GREATER than 200 mcg/hr fentanyl, contact MD to re-evaluate sedation therapy

○ **hydromorPHONE (DILAUDID) 50 mg/50 mL in sodium chloride 0.9% infusion Dose:** 1 **Route:** intravenous **Frequency:** continuous
Admin Instructions:
LESS than desired sedation effect: administer bolus and increase rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
DESIRED sedation effect: Continue the same rate. Reassess sedation within 4 hrs
GREATER than desired sedation effect: Decrease rate by 0.5 mg/hr and reassess RASS/BIS within 30 mins until at goal
If patient requires GREATER than 2 mg/hr hydromorphone, contact MD to re-evaluate sedation therapy
Maximum recommended dose 3 mg/hr

☐ **fentanyl (SUBLIMAZE) or hydromorPHONE (DILAUDID) infusion - NOT HMSJ**

○ **fentaNYL (SUBLIMAZE) 1500 mcg/30 mL infusion Dose:** 50 **Frequency:** continuous
Admin Instructions:
LESS than desired sedation effect: administer bolus and increase rate by 25mcg/hr then reassess RASS/BIS within 30 mins until at goal
DESIRED sedation effect: Continue the same rate. Reassess sedation within 4 hrs
GREATER than desired sedation effect: Decrease rate by 25 mcg/hr and reassess RASS/BIS within 30 mins until at goal
If patient requires GREATER than 200 mcg/hr fentanyl, contact MD to re-evaluate sedation therapy

○ **hydromorPHONE (DILAUDID) 15 mg/30 mL infusion Dose:** .5 **Route:** intravenous **Frequency:** continuous
Admin Instructions:
LESS than desired sedation effect: administer bolus and increase rate by 0.5 mg/hr then reassess RASS/BIS within 30 mins until at goal
DESIRED sedation effect: Continue the same rate. Reassess sedation within 4 hrs
GREATER than desired sedation effect: Decrease rate by 0.5 mg/hr and reassess RASS/BIS within 30 mins until at goal
If patient requires GREATER than 2 mg/hr hydromorphone, contact MD to re-evaluate sedation therapy
Maximum recommended dose 3 mg/hr

Antitussives

○ **guaiFENesin (MUCINEX) 12 hr tablet Dose:** 1200 mg **Route:** oral **Frequency:** every 12 hours PRN **PRN Reasons:** cough

○ **benzonatate (TESSALON) capsule Dose:** 200 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** cough

☐ **acetaminophen (TYLENOL, OFIRMEV) oral/IV**

☐ **acetaminophen (TYLENOL) tablet Dose:** 500 mg **Route:** oral **Frequency:** every 4 hours PRN **PRN Comment:** Fever GREATER than 100.5 F **PRN Reasons:** fever
Question(s):
Allowance for Patient Preference:

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

Stress Ulcer Prophylaxis

○ **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

◉ **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:** 40 mg **Route:** Nasogastric **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
Separate administration with all other oral medications by 1 hour.

Dexamethasone PO or IV
-Dexamethasone should only be used in COVID-19 patients (a) requiring oxygen supplementation or (b) requiring ventilator support.
-Caution in using steroids early in COVID-19 disease (i.e. symptoms less than 7 days).

○ **dexamethasone (DECADRON) tablet Dose:** 6 mg **Route:** oral **Frequency:** daily **Frequency Limit:** 10 Occurrences

○ **dexamethasone (DECADRON) IV Dose:** 6 mg **Route:** intravenous **Frequency:** daily **Frequency Limit:** 10 Occurrences

○ **dexamethasone 4 mg/mL oral suspension Dose:** 6 mg **Route:** oral **Frequency:** daily **Frequency Limit:** 10 Occurrences
Admin Instructions:
Note: Suspension is alcohol-free

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

Antiemetics

☐ **ondansetron (ZOFRAN) IV Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
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.

Antiemetics

☐ **ondansetron (ZOFRAN) IV Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea vomiting
Product Admin Instructions:
May cause QTc prolongation.

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

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

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

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

Antiemetics

☐ **ondansetron (ZOFRAN) IV Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea vomiting
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.

Constipation

○ **bisacodyl (DULCOLAX) EC tablet Dose:** 10 mg **Route:** oral **Frequency:** daily PRN **PRN Reasons:** constipation

○ **bisacodyl (DULCOLAX) suppository Dose:** 10 mg **Route:** rectal **Frequency:** daily PRN **PRN Reasons:** constipation

○ **lactulose solution Dose:** 20 g **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** constipation

○ **polyethylene glycol (GLYCOLAX) packet Dose:** 17 g **Route:** oral **Frequency:** daily PRN **PRN Reasons:** constipation
Product Admin Instructions:
Mix in 4-8oz of water.

○ **docusate (COLACE) 50 mg/5 mL liquid Dose:** 50 **Route:** Nasogastric **Frequency:** 2 times daily PRN **PRN Reasons:** constipation

○ **docusate sodium (COLACE) capsule Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily

Eye Care

☐ **artificial tears ointment Route:** Both Eyes **Frequency:** every 4 hours PRN **PRN Reasons:** dry eyes
Admin Instructions:
Required for patients on paralytic agents or seventh cranial nerve palsy (Bell's Palsy)

☐ **hypromellose (NATURES TEARS) ophthalmic solution Dose:** 2 drop **Route:** Both Eyes **Frequency:** every 2 hour PRN **PRN Reasons:** dry eyes
Admin Instructions:
Required for patients on paralytic agents or seventh cranial nerve palsy (Bell's Palsy)
Product Admin Instructions:
For Ophthalmic use only

☐ **Pain/Analgesia**

☐ **PRN Mild Pain (Pain Score 1-3) or Fever**
(adjust dose for renal/liver function and age)

○ **acetaminophen (TYLENOL) tablet OR oral suspension**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

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

☐ **PRN Oral Medications for Moderate Pain (Pain Score 4-6): For Patients LESS than 65 years old**
(adjust dose for renal/liver function and age)

○ **acetaminophen-codeine (TYLENOL #3) tablet OR oral solution**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **acetaminophen-codeine (TYLENOL #3) 300-30 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.

◉ **acetaminophen-codeine 300 mg-30 mg /12.5 mL solution Dose:** 12.5 mL **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot swallow tablet.

○ **HYDROcodone-acetaminophen 5/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution Dose:** 10 mL **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
If patient cannot swallow tablet.

○ **HYDROcodone-acetaminophen 7.5/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

◉ **HYDROcodone-acetaminophen (HYCET) 7.5-325 mg/15 mL solution Dose:** 15 mL **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot swallow tablet.

○ **HYDROcodone-acetaminophen 10/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO 10-325) 10-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.

◉ **HYDROcodone-acetaminophen (HYCET) 7.5-325 mg/15 mL solution Dose:** 20 mL **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient can not swallow tablet.

○ **traMADol (ULTRAM) tablet - For eGFR LESS than 30 mL/min, change frequency to every 12 hours) Dose:** 50 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
(Max Daily dose not to exceed 200 mg/day).

Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **PRN Oral Medications for Moderate Pain (Pain Score 4-6): For Patients GREATER than 65 years old**
(adjust dose for renal/liver function and age)

○ **acetaminophen-codeine (TYLENOL #3) tablet OR oral solution**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **acetaminophen-codeine (TYLENOL #3) 300-30 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.

◉ **acetaminophen-codeine 300 mg-30 mg /12.5 mL solution Dose:** 12.5 mL **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot swallow tablet.

○ **HYDROcodone-acetaminophen 5/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution Dose:** 10 mL **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
If patient cannot swallow tablet.

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

○ **traMADol (ULTRAM) tablet - For eGFR LESS than 30 mL/min, change frequency to every 12 hours) Dose:** 25 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
(Max Daily dose not to exceed 200 mg/day).

Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **PRN IV Medications for Moderate Pain (Pain Score 4-6): For Patients LESS than 65 years old**
(adjust dose for renal/liver function and age)

○ **fentaNYL (SUBLIMAZE) injection Dose:** 25 mcg **Route:** intravenous **Frequency:** every 2 hour PRN **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

○ **morphine 2 mg/mL injection Dose:** 2 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

○ **HYDROmorphone (DILAUDID) injection Dose:** 0.5 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

☐ **PRN IV Medications for Moderate Pain (Pain Score 4-6): For Patients GREATER than 65 years old**
(adjust dose for renal/liver function and age)

○ **fentaNYL (SUBLIMAZE) injection Dose:** 12.5 mcg **Route:** intravenous **Frequency:** every 2 hour PRN **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

○ **morphine 2 mg/mL injection Dose:** 1 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

○ **HYDROmorphone (DILAUDID) injection Dose:** 0.2 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

☐ **PRN Oral Medications for Severe Pain (Pain Score 7-10): For Patients LESS than 65 years old**
(adjust dose for renal/liver function and age)

○ **HYDROmorphone (DILAUDID) tablet Dose:** 2 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **morphine (MSIR) tablet Dose:** 15 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule. Do not crush, split, or chew.

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

○ **oxyCODONE (ROXICODONE) immediate release tablet Dose:** 10 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **PRN Oral Medications for Severe Pain (Pain Score 7-10): For Patients GREATER than 65 years old**
(adjust dose for renal/liver function and age)

○ **HYDROcodone-acetaminophen (NORCO) 7.5-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **HYDROcodone-acetaminophen (NORCO 10-325) 10-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.

○ **HYDROmorphone (DILAUDID) tablet Dose:** 2 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **morphine (MSIR) tablet Dose:** 15 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule. Do not crush, split, or chew.

○ **oxyCODONE (ROXICODONE) immediate release tablet Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **PRN IV Medications for Severe Pain (Pain Score 7-10): For Patients LESS than 65 years old**
(adjust dose for renal/liver function and age)

○ **fentaNYL (SUBLIMAZE) injection Dose:** 50 mcg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

○ **morphine injection Dose:** 4 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

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

○ **HYDROmorphone (DILAUDID) injection Dose:** 0.8 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

☐ **PRN IV Medications for Severe Pain (Pain Score 7-10): For Patients GREATER than 65 years old**
(adjust dose for renal/liver function and age)

○ **fentaNYL (SUBLIMAZE) injection Dose:** 25 mcg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

○ **morphine injection Dose:** 2 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

○ **HYDROmorphone (DILAUDID) injection Dose:** 0.5 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

Insomnia

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

Respiratory Inhalers

☐ **albuterol (PROAIR HFA) inhaler Dose:** 2 puff **Route:** inhalation **Frequency:** every 4 hours PRN **PRN Reasons:** wheezing
Admin Instructions:
MDI with spacer only

☐ **ipratropium (ATROVENT HFA) inhaler Dose:** 2 puff **Route:** inhalation **Frequency:** every 4 hours PRN **PRN Reasons:** wheezing
shortness of breath
Admin Instructions:
MDI with spacer only

☐ **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

DVT Risk and Prophylaxis Tool 1
1
VTE/DVT Risk Definitions (\\epic-nas.et0922.epichosted.com\static\OrderSets\VTEDVTRISKDEFINITIONS.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):

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

○ **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**

○ **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)

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

☑ **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.

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

○ **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:

○ **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):

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

◉ **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:

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**

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

☑ **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)**

○ **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:

☐ **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:

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.

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

○ **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:

○ **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):

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

◉ **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

○ **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**

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

○ **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 (Hip/Knee)** (Required)

☑ **High Risk** (Required)

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

☑ **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:

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:

☐ **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):

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:

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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.

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○ **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:

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 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

Laboratory- COVID-19 Admission labs

☑ **CBC with platelet and differential Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Comprehensive metabolic panel Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Prothrombin time with INR Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☑ **Partial thromboplastin time, activated (PTT)** **Frequency:** STAT **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.

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

☑ **NT-proBNP** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Myoglobin** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Procalcitonin** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Creatine kinase, total (CPK)** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **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)

☑ **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.

☐ **hCG qualitative, urine screen** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Laboratory-COVID-19 Inflammatory bundle

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

☑ **Interleukin 6** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Ferritin level** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **D-dimer** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **LDH** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Triglycerides** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Fibrinogen** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lactic acid level - Now and repeat 2x every 3 hours** **Frequency:** Now and repeat 2x every 3 hours **Frequency Limit:** 3 Occurrences **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, activated** **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.

HM IP COVID-19 REPEAT ADMISSION LABS

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

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

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

☐ **ADDITIONAL DAILY LABS for Critical Illness/Clinical Deterioration**
ADDITIONAL DAILY LABS for Critical Illness/Clinical Deterioration

☑ **Troponin T** **Frequency:** AM draw repeats **Frequency Limit:** 3 Occurrences **Start Date:** S+1 **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **D-dimer** **Frequency:** AM draw repeats **Frequency Limit:** 3 Occurrences **Start Date:** S+1 **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **LDH** **Frequency:** AM draw repeats **Frequency Limit:** 3 Occurrences **Start Date:** S+1 **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Ferritin level** **Frequency:** AM draw repeats **Frequency Limit:** 3 Occurrences **Start Date:** S+1 **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Laboratory-Type and Screen

☑ **Type and screen** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood

Cardiology

COVID-19 ICU CARDIOLOGY

☑ **ECG 12 lead upon admission** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Maximum Quantity:** 6
Question(s):
Clinical Indications: ○ Rate/Rhythm
Interpreting Physician:

☐ **ECG 12 lead daily** **Frequency:** Daily **Frequency Limit:** 3 Occurrences **Priority:** Routine **Maximum Quantity:** 6
Question(s):
Clinical Indications:
Interpreting Physician:

☐ **Transthoracic Echocardiogram Complete, (w Contrast, Strain 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

Imaging

☑ **XR 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.):

☐ **Daily XR Chest 1 Vw Portable** **Frequency:** Daily imaging **Frequency Limit:** -1 Occurrences **Start Date:** S+1 **Priority:** Routine **Comments:** Consider daily CXR for the following patients: Age > 70, BMI > 40, or Increasing O2 requirements on the floor.
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Respiratory

COVID-19 ICU RESPIRATORY

Click here for COVID-19 Oxygen therapy algorithm (\\epic-nas.et0922.epichosted.com\static\OrderSets\COVID19 Hypoxemia Algorithm.pdf)

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

☐ **Mechanical ventilation** **Frequency:** Continuous **Priority:** Routine
Question(s):
Mechanical Ventilation:
Vent Management Strategies: Adult Respiratory Ventilator Protocol

☐ **Oxygen therapy-** **Frequency:** Continuous **Priority:** Routine
Question(s):
Initial Device:
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 **Frequency Limit:** 1 Occurrences **Priority:** Routine
Question(s):
Frequency of use: ○ Every 2 hours while awake

Physician Consults

COVID-19 PHYSICIAN CONSULTS

Consider using these consults to assist with management of the COVID-19 positive patient.

☐ **Consult Infectious Diseases for moderate to severe COVID-19 patient** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult? ○ Management of COVID-19 positive patient
Provider Group:
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

☐ **Consult Hematology and Oncology for suspected Cytokine Storm** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult? ○ Management of COVID-19 positive patient with suspected Cytokine Storm
Provider Group:
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

☐ **Consult Pulmonary/Crit Care for respiratory insufficiency** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for Consult? ○ Management of COVID-19 positive patient with respiratory insufficiency
Provider Group:
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

☐ **Consult Nephrology/Hyperten** **Frequency:** Once **Priority:** Routine
Question(s):
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

Ancillary Consults

COVID-19 CONSULTS

☐ **Consult to Palliative Care Service**

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

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

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

Additional Orders

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