Location: _____

General

Common Present on Admission Diagnosis

- ☐ **Acidosis** **Frequency:** Once **Priority:** Routine
- ☐ **Acute Post-Hemorrhagic Anemia** **Frequency:** Once **Priority:** Routine
- ☐ **Acute Renal Failure** **Frequency:** Once **Priority:** Routine
- ☐ **Acute Respiratory Failure** **Frequency:** Once **Priority:** Routine
- ☐ **Acute Thromboembolism of Deep Veins of Lower Extremities** **Frequency:** Once **Priority:** Routine
- ☐ **Anemia** **Frequency:** Once **Priority:** Routine
- ☐ **Bacteremia** **Frequency:** Once **Priority:** Routine
- ☐ **Bipolar disorder, unspecified** **Frequency:** Once **Priority:** Routine
- ☐ **Cardiac Arrest** **Frequency:** Once **Priority:** Routine
- ☐ **Cardiac Dysrhythmia** **Frequency:** Once **Priority:** Routine
- ☐ **Cardiogenic Shock** **Frequency:** Once **Priority:** Routine
- ☐ **Decubitus Ulcer** **Frequency:** Once **Priority:** Routine
- ☐ **Dementia in Conditions Classified Elsewhere** **Frequency:** Once **Priority:** Routine
- ☐ **Disorder of Liver** **Frequency:** Once **Priority:** Routine
- ☐ **Electrolyte and Fluid Disorder** **Frequency:** Once **Priority:** Routine
- ☐ **Intestinal Infection due to Clostridium Difficile** **Frequency:** Once **Priority:** Routine
- ☐ **Methicillin Resistant Staphylococcus Aureus Infection** **Frequency:** Once **Priority:** Routine
- ☐ **Obstructive Chronic Bronchitis with Exacerbation** **Frequency:** Once **Priority:** Routine
- ☐ **Other Alteration of Consciousness** **Frequency:** Once **Priority:** Routine
- ☐ **Other and Unspecified Coagulation Defects** **Frequency:** Once **Priority:** Routine
- ☐ **Other Pulmonary Embolism and Infarction** **Frequency:** Once **Priority:** Routine
- ☐ **Phlebitis and Thrombophlebitis** **Frequency:** Once **Priority:** Routine
- ☐ **Protein-calorie Malnutrition** **Frequency:** Once **Priority:** Routine
- ☐ **Psychosis, unspecified psychosis type** **Frequency:** Once **Priority:** Routine
- ☐ **Schizophrenia Disorder** **Frequency:** Once **Priority:** Routine
- ☐ **Sepsis** **Frequency:** Once **Priority:** Routine
- ☐ **Septic Shock** **Frequency:** Once **Priority:** Routine
- ☐ **Septicemia** **Frequency:** Once **Priority:** Routine
- ☐ **Type II or Unspecified Type Diabetes Mellitus with Mention of Complication, Not Stated as Uncontrolled** **Frequency:** Once **Priority:** Routine
- ☐ **Urinary Tract Infection, Site Not Specified** **Frequency:** Once **Priority:** Routine

Admission or Observation (Required)

- ○ **Admit to inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Priority:** Routine

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

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

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

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

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

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

Admission or Observation

Patient has active status order on file

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

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

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

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

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

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

Admission

Patient has active status order on file.

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

Admission or Observation (Required)

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

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

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

Admission or Observation

Patient has status order on file

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

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

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

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

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

☐ **Airborne isolation status**

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

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

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

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

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

Precautions

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

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

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

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

Nursing

Activity

☐ **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

☐ **Ambulate with assistance** **Frequency:** 3 times daily **Priority:** Routine
Question(s):
Specify: ○ with assistance

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

Nursing Care

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

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

☐ **Strict intake and output** **Frequency:** Every hour **Priority:** Routine

☐ **Measure central venous pressure** **Frequency:** Once **Priority:** Routine

☐ **Insert and maintain Foley**

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

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

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

☐ **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

☐ **Nasogastric tube insert and maintain**

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

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

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

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

☐ **Assist with feeding patient** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Modifier:

☐ **Peripheral vascular assessment** **Frequency:** Once **Priority:** Routine

Diet

☐ **NPO** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
NPO:
Pre-Operative fasting options:
Process Instructions:
An NPO order without explicit exceptions means nothing can be given orally to the patient.

☐ **Diet - Fluid restriction 500mL** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
Fluid Restriction: ○ Fluid Restriction 500 ml
Diet(s):
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Foods to Avoid:
Foods to Avoid:

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

☐ **Diet - Fluid restriction 1000 mL** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
Fluid Restriction: ○ Fluid Restriction 1000 ml
Diet(s):
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Foods to Avoid:
Foods to Avoid:

☐ **Diet - 2 gm sodium** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
Diet(s): ○ Other Chol/Fat/Sodium
Chol/Fat/Sodium: 2 GM Sodium
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

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

☐ **Diet - Renal (80 mg Pro, 2-3gm Na, 2-3 gm K)** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
Diet(s): ○ Renal (80GM Pro, 2-3GM Na, 2-3GM K)
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

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

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

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

Notify

☐ **Notify Physician(vitals,output,pulse ox)** **Frequency:** Until discontinued **Priority:** Routine **Comments:** Notify ICU on-call
Question(s):
Heart rate greater than (BPM): 100
Heart rate less than (BPM): ○ 50 ○ 60
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
MAP less than: 60.000
Respiratory rate greater than: 25
Respiratory rate less than: 8
SpO2 less than: 92

IV Fluids

Peripheral IV Access

☑ **Initiate and maintain IV**

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

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

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

IV Bolus

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

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

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

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

○ **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

Maintenance IV Fluids

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

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

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

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

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

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

IV Fluids with Potassium

☐ **dextrose 5 % and sodium chloride 0.45 % with KCl 20 mEq/L infusion Dose:** 20 **Route:** intravenous **Frequency:** continuous

☐ **dextrose 5 % and sodium chloride 0.9 % with KCl 20 mEq/L infusion Dose:** 20 **Route:** intravenous **Frequency:** continuous

☐ **dextrose 5 % and sodium chloride 0.9 % with potassium chloride 20 mEq/L infusion Dose:** 20 **Frequency:** continuous

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.

☐ **Pharmacy consult to change all IV fluids to dextrose 5% (EXCLUDES HEPARIN INFUSIONS) Frequency:** Until discontinued **Priority:** Routine

☐ **Pharmacy consult to change all IV fluids to normal saline (EXCLUDES HEPARIN INFUSIONS) Frequency:** Until discontinued **Priority:** Routine

Ascites

☐ **furosemide (LASIX) injection Dose:** 10 **Route:** intravenous **Frequency:** daily at 0900 **Priority:** STAT
Admin Instructions:
Inject each 20 mg of furosemide slowly IV over 1 to 2 minutes

☐ **furosemide (LASIX) 40 mg/5 mL solution Dose:** 40 mg/5 mL **Route:** oral **Frequency:** daily at 0900 **Priority:** STAT

☐ **spironolactone (ALDACTONE) tablet Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily at 0900, 1700 **Priority:** STAT
Question(s):
BP HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Monitor potassium levels. Avoid salt substitutes unless approved by MD.
Product Admin Instructions:
Hazardous medication – if needing crushed, request from pharmacy

Spont. Bacterial Peritonitis

☐ **ceftriaxone (ROCEPHIN) IV Dose:** 2 g **Route:** intravenous **Frequency:** every 24 hours **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

☐ **piperacillin-tazobactam (ZOSYN) IV Dose:** 4.5 g **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.

☐ **ciprofloxacin (CIPRO) IV Dose:** 400 mg **Route:** intravenous **Frequency:** every 12 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:
Product Admin Instructions:
May cause QTc prolongation.

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

Encephalopathy

☐ **lactulose solution Dose:** 20 g **Route:** oral **Frequency:** every 1 hour
Admin Instructions:
Stop after first bowel movement and go to three times daily dosing.

☐ **lactulose solution Dose:** 20 g **Route:** oral **Frequency:** every 8 hours

☐ **rifaximin (XIFAXAN) tablet Dose:** 550 mg **Route:** oral **Frequency:** every 12 hours
Question(s):
Indication:

☐ **neomycin (MYCIFRADIN) tablet Dose:** 1000 mg **Route:** oral **Frequency:** every 6 hours
Question(s):
Indication:

☐ **lactulose solution for rectal enema Dose:** 200 g **Route:** rectal **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Mix 300 mL of lactulose with 700 mL of water or normal saline and administer rectally via enema. Patient should retain for 30 to 60 minutes.

Hepatorenal

☐ **midodrine (PROAMATINE) tablet Dose:** 10 mg **Route:** oral **Frequency:** 3 times daily at 0900, 1300, 1700
Question(s):
HOLD parameters for this order:
Admin Instructions:
Hold for systolic blood pressure greater than 130 mmHg.

☐ **octreotide (SANDOSTATIN) injection Dose:** 100 mcg **Route:** subcutaneous **Frequency:** every 8 hours

☐ **albumin human 25 % bottle Dose:** 25 g **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 2 Days
Question(s):
Indication: ○ Hepatorenal Syndrome

GI Bleeding/Prophylaxis

☐ **propranolol (INDERAL) tablet Dose:** 20 mg **Route:** oral **Frequency:** 2 times daily
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Hold for HR less than 50 or SBP less than 90

☐ **phytonadione (AQUA-MEPHYTON) injection Dose:** 10 mg **Route:** intravenous **Frequency:** every 24 hours **Frequency Limit:** 3 Days
Question(s):
Indication:
Product Admin Instructions:
Subcutaneous absorption variable. Consider IVPB use.

☐ **pantoprazole (PROTONIX) EC tablet Dose:** 40 mg **Route:** oral **Frequency:** every 24 hours
Question(s):
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

☐ **omeprazole (PriLOSEC) 5 mg/mL suspension Dose:** 40 mg **Route:** oral **Frequency:** every 24 hours

☐ **pantoprazole (PROTONIX) IV Dose:** 40 mg **Route:** intravenous **Frequency:** daily before breakfast
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:

☐ **pantoprazole (PROTONIX) IV Dose:** 80 mg **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:
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
LOADING DOSE

GI Bleeding IV Infusion

☐ **pantoprazole (PROTONIX) 80 mg in sodium chloride 0.9 % 100 mL infusion Dose:** 8 mg/hr **Route:** intravenous **Frequency:** continuous
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

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

☐ **octreotide (SandoSTATIN) in sodium chloride 0.9 % 100 mL infusion** **Dose:** 1000 mcg/hr **Route:** intravenous **Frequency:** continuous
Admin Instructions:
May cause Q-T interval prolongation

☐ **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

VTE Risk and Prophylaxis Tool (Required)

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

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

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

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

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

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication. Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication. Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication. Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication. Therapy for the following:

☑ **Place sequential compression device**

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

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **LOW Risk of VTE** (Required)

☑ **Low Risk** (Required)

◉ **Low risk of VTE** **Frequency:** Once **Priority:** Routine
Question(s):
Low risk: ○ Due to low risk, no VTE prophylaxis is needed. Will encourgae early ambulation ○ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

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

☑ **Moderate Risk** (Required)

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Moderate Risk Pharmacological Prophylaxis - Surgical Patient** (Required)

○ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

○ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)
Patient renal status: @CRCL@

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

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

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

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

○ **Medications**

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

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

☐ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

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

☑ **Moderate Risk** (Required)

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

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

○ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

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

Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700 **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT), do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

○ **heparin**

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

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

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

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

- ○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled
- ○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

- ○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled
- ○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

☐ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **HIGH Risk of VTE - Surgical** (Required)

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

☑ **High Risk Pharmacological Prophylaxis - Surgical Patient** (Required)

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

○ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)
Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

☐ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

☑ **High Risk Pharmacological Prophylaxis - Non-Surgical Patient** (Required)

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

○ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical** (Required)
Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

○ **High Bleed Risk**

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

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

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

○ **Medications**

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

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

☐ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

☑ **High Risk Pharmacological Prophylaxis - Hip or Knee (Arthroplasty) Surgical Patient** (Required)

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

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

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

○ **Apixaban and Pharmacy Consult** (Required)

☑ **apixaban (ELIQUIS) tablet Dose:** 2.5 mg **Frequency:** 2 times daily **Start Date:** S+1
Question(s):
Indications: ○ VTE prophylaxis

☑ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy Frequency:** Until discontinued **Priority:** STAT
Question(s):
Indications: VTE prophylaxis

○ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)
Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Rivaroxaban and Pharmacy Consult** (Required)

☑ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission Dose:** 10 mg **Frequency:** daily at 0600 (TIME CRITICAL)
Question(s):
Indications: ○ VTE prophylaxis
Admin Instructions:
For Xarelto 15 mg and 20 mg, give with food or follow administration with enteral feeding to increase medication absorption. Do not administer via post-pyloric routes.

☑ **Pharmacy consult to monitor rivaroxaban (XARELTO) therapy Frequency:** Until discontinued **Priority:** STAT
Question(s):
Indications: VTE prophylaxis

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

☐ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

VTE Risk and Prophylaxis Tool

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

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

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

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

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

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

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

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **LOW Risk of VTE** (Required)

☑ **Low Risk** (Required)

◉ **Low risk of VTE** **Frequency:** Once **Priority:** Routine
Question(s):
Low risk: ○ Due to low risk, no VTE prophylaxis is needed. Will encourgae early ambulation ○ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

○ **Moderate Risk of VTE - Surgical** (Required)

☑ **Moderate Risk** (Required)

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Moderate Risk Pharmacological Prophylaxis - Surgical Patient** (Required)

○ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

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

Patient renal status: @CRCL@

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

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

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

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

○ **Medications**

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

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

☐ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Moderate Risk** (Required)

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

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

○ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

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

Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT), do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

○ **heparin**

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

○ **High Bleed Risk**

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

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

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

○ **Medications**

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

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

☐ **Mechanical Prophylaxis** (Required)

○ **Contraindications exist for mechanical prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

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

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

☑ **High Risk Pharmacological Prophylaxis - Surgical Patient** (Required)

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

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

Patient renal status: @CRCL@

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

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

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

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

○ **Medications**

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

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

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

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

☑ **High Risk** (Required)

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **High Risk Pharmacological Prophylaxis - Non-Surgical Patient** (Required)

○ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

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

Patient renal status: @CRCL@

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection** **Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection** **Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection** **Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

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

○ **heparin**

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

○ **High Bleed Risk**

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

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

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

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

☑ **High Risk** (Required)

☑ **High risk of VTE Frequency:** Once **Priority:** Routine

☑ **High Risk Pharmacological Prophylaxis - Hip or Knee (Arthroplasty) Surgical Patient** (Required)

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

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

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

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

○ **Apixaban and Pharmacy Consult** (Required)

☑ **apixaban (ELIQUIS) tablet Dose:** 2.5 mg **Frequency:** 2 times daily **Start Date:** S+1
Question(s):
Indications: ○ VTE prophylaxis

☑ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy Frequency:** Until discontinued **Priority:** STAT
Question(s):
Indications: VTE prophylaxis

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

Patient renal status: @CRCL@

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700 **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

○ **heparin**

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

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

○ **High Bleed Risk**

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

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

○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled

○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **Rivaroxaban and Pharmacy Consult** (Required)

☑ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission Dose:** 10 mg **Frequency:** daily at 0600 (TIME CRITICAL)
Question(s):
Indications: ○ VTE prophylaxis
Admin Instructions:
For Xarelto 15 mg and 20 mg, give with food or follow administration with enteral feeding to increase medication absorption. Do not administer via post-pyloric routes.

☑ **Pharmacy consult to monitor rivaroxaban (XARELTO) therapy Frequency:** Until discontinued **Priority:** STAT
Question(s):
Indications: VTE prophylaxis

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

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

VTE Risk and Prophylaxis Tool

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

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

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

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

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

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☑ **High risk of VTE** **Frequency:** Once **Priority:** Routine

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

☑ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication. Therapy for the following:

☑ **Place sequential compression device**

○ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

◉ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **LOW Risk of VTE** (Required)

☑ **Low Risk** (Required)

◉ **Low risk of VTE** **Frequency:** Once **Priority:** Routine
Question(s):
Low risk: ○ Due to low risk, no VTE prophylaxis is needed. Will encourgae early ambulation ○ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

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

☑ **Moderate Risk** (Required)

☑ **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

☑ **Moderate Risk Pharmacological Prophylaxis - Surgical Patient** (Required)

○ **Contraindications exist for pharmacologic prophylaxis - Order Sequential compression device**

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

○ **Contraindications exist for pharmacologic prophylaxis AND mechanical prophylaxis**

☑ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

☑ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine
Question(s):
No mechanical VTE prophylaxis due to the following contraindication(s):

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

Patient renal status: @CRCL@

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

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

Labs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ **Urinalysis screen and microscopy, with reflex to culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Urine
Question(s):
Specimen Source: Urine
Specimen Site:
Primary Ordering Comments:
Specimen must be received in the laboratory within 2 hours of collection.

☐ **Type and screen** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood

☐ **Alpha fetoprotein** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Daily AM Labs

☐ **Albumin** **Frequency:** AM draw repeats **Frequency Limit:** 3 Days **Start Date:** S **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lactate dehydrogenase** **Frequency:** AM draw repeats **Frequency Limit:** 3 Days **Start Date:** S **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Cystatin C with eGFR** **Frequency:** AM draw repeats **Frequency Limit:** 3 Days **Start Date:** S **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Do not order if patient is ESRD/on dialysis.

Peritoneal Fluid Study - Tube 1

☐ **Albumin, misc fluid** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** STAT **Specimen Type:** Peritoneal fluid
Question(s):
Specimen Source: ○ Peritoneal

☐ **Amylase level, misc fluid** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Body fluid
Question(s):
Specimen Source: ○ Peritoneal

☐ **Glucose, misc fluid** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** STAT **Specimen Type:** Peritoneal fluid
Question(s):
Specimen Source: ○ Peritoneal

☐ **LDH, misc fluid** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** STAT **Specimen Type:** Peritoneal fluid
Question(s):
Specimen Source: ○ Peritoneal

☐ **Protein, misc fluid** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** STAT **Specimen Type:** Peritoneal fluid
Question(s):
Specimen Source: ○ Peritoneal

Peritoneal Fluid Study - Tube 2

☐ **Cell count and differential, body fluid** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** STAT **Specimen Type:** Peritoneal fluid
Question(s):
Specimen Source: ○ Peritoneal

Other Container

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

☐ **Cytology (non-gynecological) request** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Other
Question(s):
Collection Date: ○ S ○ T
Collection Time: ○ 51240 ○ N
Specimen Source: ○ Peritoneal
Specimen Type: ○ Fluid
Special Stains:
Clinical History:
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
A paper requisition will print when this order is submitted. The printout must accompany the specimen to the lab.

☐ **Gram stain** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Peritoneal fluid

☐ **Specific gravity, body fluid** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Peritoneal fluid
Question(s):
Specimen Source:

☐ **Triglycerides, body fluid** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Peritoneal fluid
Question(s):
Specimen Source:

Aerobic/Anaerobic Cultures

☐ **Aerobic culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Peritoneal fluid **Comments:** Place specimen in blood culture bottle as soon as collected

☐ **Anaerobic culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Peritoneal fluid **Comments:** Place specimen in blood culture bottle as soon as collected

Paracentesis Cultures

☐ **Fungus culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Peritoneal fluid

☐ **AFB culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Peritoneal fluid

☐ **AFB stain** **Frequency:** Once **Priority:** Routine **Specimen Type:** Peritoneal fluid

Microbiology

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

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

@LASTPROCRESULT(LAB462)@

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

☑ **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.

Cardiology

Cardiology

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

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

☐ **Echocardiogram 2d complete with contrast** **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.

Diagnostic Imaging

CT

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

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

Fasting for this test is not required.

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

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

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

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

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

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

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

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

Fasting for this test is not required.

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

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

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

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

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

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

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

Fasting for this test is not required.

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

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

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

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

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

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

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

Fasting for this test is not required.

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

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

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

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

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

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

☐ **CT Brain**

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

Fasting for this test is not required.

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

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

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

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

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

Fasting for this test is not required.

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

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

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

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

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

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

Fasting for this test is not required.

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

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

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

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

X-Ray

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

☐ **Chest 2 Vw** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **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.):

US

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

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

Other Diagnostic Studies

Respiratory

Respiratory

☐ **Incentive spirometry instructions** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
Question(s):
Frequency of use: ○ Every hour

Rehab

Consults

Ancillary Consults

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

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

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

☐ **Consult PT eval and treat** **Frequency:** Once **Priority:** Routine
Question(s):
Reasons for referral to Physical Therapy (mark all applicable):
Are there any restrictions for positioning or mobility?
Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):
Weight Bearing Status:
Reason for PT?
Process Instructions:
If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting physical therapy

If the patient currently has an order for bed rest, please consider revising the activity order to accommodate therapy

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

☐ **Consult OT eval and treat** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for referral to Occupational Therapy (mark all that apply):
Are there any restrictions for positioning or mobility?
Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):
Weight Bearing Status:
Reason for OT?
Process Instructions:
If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting occupational therapy

If the patient currently has an order for bed rest, please consider revising the activity order to accommodate therapy.

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

☐ **Consult to Spiritual Care** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for consult?
Reason for Consult?
Process Instructions:
For requests after hours, call the house operator.

☐ **Consult to Speech Language Pathology** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for consult:
Reason for SLP?

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

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

Additional Orders

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