

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: _____

☐ **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 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.

☐ **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

Patient has active status order on file.

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

Question(s):

Admitting Physician:

Level of Care:

Patient Condition:

Bed request comments:

Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

Code Status

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

☒ **Code Status**

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

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

Question(s):

Code Status decision reached by:

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

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

Question(s):

Did the patient/surrogate require the use of an interpreter?

Did the patient/surrogate require the use of an interpreter?

Does patient have decision-making capacity?

I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT

Active until Signed by the Responsible Attending Physician.:

Code Status decision reached by:

☐ **Consult to Palliative Care Service**

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

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

Question(s):

Priority:

Reason for Consult?

Order?

Name of referring provider:

Enter call back number:

Reason for Consult?

Process Instructions:

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

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

Question(s):

Reason for Consult:

Reason for Consult?

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

Question(s):

Did the patient/surrogate require the use of an interpreter?

Did the patient/surrogate require the use of an interpreter?

Does patient have decision-making capacity?

Modified Code restrictions:

I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT Active until Signed by the Responsible Attending Physician.:

Code Status decision reached by:

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

Treatment Restrictions Priority: Routine

Question(s):

I understand that if the patient is NOT in a cardiopulmonary arrest, the selected treatments will NOT be provided. I understand that all other unselected medically indicated treatments will be provided.:

Treatment Restriction decision reached by:

Specify Treatment Restrictions:

Code Status decision reached by:

Process Instructions:

Treatment Restrictions is NOT a Code Status order. It is NOT a Modified Code order. It is strictly intended for Non Cardiopulmonary situations.

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

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

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

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:

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

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

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

Question(s):

Increased observation level needed:

Nursing

Vital Signs

☐ **Vital signs - Every 4 hrs** Frequency: Every 4 hours Priority: Routine

☐ **Vital signs - Every shift** Frequency: Every shift Priority: Routine

Activity

☐ **Activity as tolerated** Frequency: Until discontinued Priority: Routine Comments: Encourage ambulation

Question(s):

Specify: ☐ Activity as tolerated

Nursing

☐ **Intake and Output** Frequency: Every 8 hours Priority: Routine

☐ **Daily weights** Frequency: Daily Priority: Routine Comments: On arrival and daily.

Diet

☐ **NPO - except sips with meds** Frequency: Diet effective now Priority: Routine

Question(s):

NPO: ☐ Except meds ☐ Except Sips with meds

Pre-Operative fasting options:

Process Instructions:

An NPO order without explicit exceptions means nothing can be given orally to the patient.

☐ **Diet -Clear Liquids, advance to GI/Soft** Frequency: Diet effective now Priority: Routine

Question(s):

Diet(s): ☐ Clear Liquids

Advance Diet as Tolerated? ☐ Yes

Target Diet: GI/Soft

Cultural/Special:

Cultural/Special:

Other Options:

Other Options:

IDDSI Liquid Consistency:

Fluid Restriction:

Foods to Avoid:

Foods to Avoid:

☐ **Diet - Frequency:** Diet effective now Priority: Routine

Question(s):

Diet(s):

Cultural/Special:

Cultural/Special:

Other Options:

Other Options:

Advance Diet as Tolerated?

IDDSI Liquid Consistency:

Fluid Restriction:

Foods to Avoid:

Foods to Avoid:

IV Fluids

Maintenance IV Fluids

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

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

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

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

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

Medications

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

Antibiotics

- ☐ **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.

- ☐ **For Penicillin Allergy - aztreonam (AZACTAM) 2 g IV + metronIDAZOLE (FLAGYL) 500 mg IV**

- ☒ **aztreonam (AZACTAM) IV Dose:** 2 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:

- ☒ **metronIDAZOLE (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT

Question(s):

Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

Indication:

Antiemetics

- ☒ **ondansetron (ZOFTRAN) IV or Oral (Required)**

- ☒ **ondansetron ODT (ZOFTRAN-ODT) disintegrating tablet Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN

PRN Reasons: nausea

vomiting

Admin Instructions:

Give if patient is able to tolerate oral medication.

Product Admin Instructions:

May cause QTc prolongation.

- ☒ **ondansetron (ZOFTRAN) 4 mg/2 mL injection Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN**

Reasons: nausea

vomiting

Admin Instructions:

Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.

Product Admin Instructions:

May cause QTc prolongation.

- ☐ **promethazine (PHENERGAN)**

- ☒ **promethazine (PHENERGAN) 12.5 mg IV Dose:** 12.5 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN**

Reasons: nausea

vomiting

Admin Instructions:

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

- ☒ **promethazine (PHENERGAN) tablet Dose:** 12.5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:**

nausea

vomiting

Admin Instructions:

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral medication.

- ☒ **promethazine (PHENERGAN) suppository Dose:** 12.5 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN**

Reasons: nausea

vomiting

Admin Instructions:

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral medication.

- ☒ **promethazine (PHENERGAN) intraMUSCULAR injection Dose:** 12.5 mg **Route:** intramuscular **Frequency:** every 6

hours PRN **PRN Reasons:** nausea

vomiting

Admin Instructions:

Give if ondansetron (ZOFTRAN) is ineffective and patient is UNable to tolerate oral medication.

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

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

☒ **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

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 :
	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 less 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: _____

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 encourage 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 $\geq$ 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 $\geq$ 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 $\geq$ 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 $\geq$ 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 $\geq$ 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](https://formweb.com/files/houstonmethodist/documents/COVID-19%20Anticoagulation%20Guideline%20-%208.20.2021v15.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 encourage 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 $\geq$ 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 $\geq$ 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 $\geq$ 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 $\geq$ 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 CharacteristicsAge $\geq$ 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](https://formweb.com/files/houstonmethodist/documents/COVID-19%20Anticoagulation%20Guideline%20-%208.20.2021v15.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 encourage 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 $\geq$ 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 $\geq$ 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 $\geq$ 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 $\geq$ 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 $\geq$ 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 Today**

- ☐ **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

Labs Tomorrow

- ☐ **CBC and differential** **Frequency:** Once **Start Date:** S+1 **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- ☐ **Basic metabolic panel** **Frequency:** Once **Start Date:** S+1 **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Microbiology

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

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

☒ **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.

☐ **Fecal lactoferrin, qualitative** Frequency: Once Priority: Routine Specimen Type: Stool

☐ **Ova & Parasites-Concentrated Examination** Frequency: Once Priority: Routine

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

☐ **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.

☐ **Gastrointestinal Pathogen Panel / Clostridioides difficile**

☒ **Gastrointestinal Pathogen Panel / Clostridioides difficile**

☐ **Gastrointestinal pathogens panel WITHOUT C diff**

☒ **Gastrointestinal pathogens panel WITHOUT C diff by nucleic acid amplification** Frequency: Once Priority: Routine Specimen Type: Stool

Primary Ordering Comments:

Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

☒ **Discontinue GI panel order if not collected in 3 days** Frequency: Until discontinued Priority: Routine Comments: This order only exists to discontinue a GI panel order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the GI panel lab has already been collected, you can discontinue this order.

Primary Ordering Comments:

This order only exists to discontinue a GI panel order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the GI panel lab has already been collected, you can discontinue this order.

☐ **Clostridioides difficile toxin**

☒ **Clostridioides difficile toxin gene (Qualitative Real-Time PCR) with reflex to antigen (Immunoassay)**

☒ **Clostridioides difficile toxin gene (Qualitative Real-Time PCR) with reflex to antigen (Immunoassay)** Frequency: Once Priority: Routine Specimen Type: Stool

Question(s):

Reason to order:

Risk factors:

Primary Ordering Comments:

Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

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

☒ **Discontinue C diff order if not collected in 3 days** Frequency: Until discontinued Priority: Routine

Comments: This order only exists to discontinue a C diff order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

Primary Ordering Comments:

This order only exists to discontinue a C diff order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

☐ **Clostridioides difficile toxin antigen (Immunoassay)**

☒ **Clostridioides difficile toxin antigen (Immunoassay)** Frequency: Once Priority: Routine

Specimen Type: Stool

Question(s):

Reason to order:

Risk factors:

Primary Ordering Comments:

Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

☒ **Discontinue C diff order if not collected in 3 days** Frequency: Until discontinued Priority: Routine

Comments: This order only exists to discontinue a C diff order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

Primary Ordering Comments:

This order only exists to discontinue a C diff order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

☒ **Patient has a previous positive C. difficile PCR in the prior 14 days. Repeat testing is not appropriate. If you have questions, please call the Microbiology Laboratory at 713-441-0330.**

@LASTLAB(CDIFFTOX,CDIFFPCR)@

☐ **Clostridioides difficile toxin antigen (Immunoassay)**

☒ **Clostridioides difficile toxin antigen (Immunoassay)** Frequency: Once Priority: Routine Specimen

Type: Stool

Question(s):

Reason to order:

Risk factors:

Primary Ordering Comments:

Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

☒ **Discontinue C diff order if not collected in 3 days** Frequency: Until discontinued Priority: Routine

Comments: This order only exists to discontinue a C diff order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

Primary Ordering Comments:

This order only exists to discontinue a C diff order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

☐ **Gastrointestinal pathogens panel WITHOUT C diff**

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

☒ **Gastrointestinal pathogens panel WITHOUT C diff by nucleic acid amplification** Frequency: Once

Priority: Routine Specimen Type: Stool

Primary Ordering Comments:

Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

☒ **Discontinue GI panel order if not collected in 3 days** Frequency: Until discontinued Priority: Routine

Comments: This order only exists to discontinue a GI panel order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the GI panel lab has already been collected, you can discontinue this order.

Primary Ordering Comments:

This order only exists to discontinue a GI panel order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the GI panel lab has already been collected, you can discontinue this order.

☒ **GI panel has been ordered or resulted negative in the past 72 hours or resulted positive in the past 14 days.** Repeat testing is not indicated at this time. If you have questions, please call the Microbiology Laboratory at 713-441-0330.

@LASTLAB(ADEN4041PCR,ASTROPCR,CAMPYLOPCR,CRYPTOPCR,CCAYETPCR,AGGECOLIPCR,EHIST

☐ **Clostridioides difficile toxin**☒ **Clostridioides difficile toxin gene (Qualitative Real-Time PCR) with reflex to antigen (Immunoassay)**☒ **Clostridioides difficile toxin gene (Qualitative Real-Time PCR) with reflex to antigen (Immunoassay)** Frequency: Once Priority: Routine Specimen Type: Stool**Question(s):**

Reason to order:

Risk factors:

Primary Ordering Comments:

Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

☒ **Discontinue C diff order if not collected in 3 days** Frequency: Until discontinued Priority:

Routine **Comments:** This order only exists to discontinue a C diff order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

Primary Ordering Comments:

This order only exists to discontinue a C diff order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

☐ **Clostridioides difficile toxin antigen (Immunoassay)**☒ **Clostridioides difficile toxin antigen (Immunoassay)** Frequency: Once Priority: Routine

Specimen Type: Stool

Question(s):

Reason to order:

Risk factors:

Primary Ordering Comments:

Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

☒ **Discontinue C diff order if not collected in 3 days** Frequency: Until discontinued Priority:

Routine **Comments:** This order only exists to discontinue a C diff order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

Primary Ordering Comments:

This order only exists to discontinue a C diff order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

☒ **Patient has a previous positive C. difficile PCR in the prior 14 days and recent GI panel order or results. Repeat testing is not appropriate. If you have questions, please call the Microbiology Laboratory at 713-441-0330. @LASTLAB(CDIFFTOX,CDIFFPCR,ADEN4041PCR,ASTROPCR,CAMPYLOPCR,CRYPTOPCR,CCAYETPCR**

☐ **Clostridioides difficile toxin antigen (Immunoassay)**☒ **Clostridioides difficile toxin antigen (Immunoassay)** Frequency: Once Priority: Routine Specimen

Type: Stool

Question(s):

Reason to order:

Risk factors:

Primary Ordering Comments:

Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

☒ **Discontinue C diff order if not collected in 3 days** Frequency: Until discontinued Priority: Routine **Comments:** This order only exists to discontinue a C diff order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

Primary Ordering Comments:

This order only exists to discontinue a C diff order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the C diff lab has already been collected, you can discontinue this order.

☐ **Patient has a previous positive C. difficile PCR in the prior 14 days and recent GI panel order or results. Repeat testing is not appropriate. If you have questions, please call the Microbiology Laboratory at 713-441-0330. Frequency: Until discontinued Priority: Routine**

☒ **C. difficile testing is not appropriate for one of the reasons below. If you have questions, please call the Microbiology Laboratory at 713-441-0330.**

C. difficile has been ordered or resulted negative in the past 72 hours.

Patient has received a laxative, enema or medication with laxative effect. C. difficile is not appropriate until laxative medication has been discontinued for 48 hours.

@LAXPRINTGROUP@

@ENEMAPRINTGROUP@

☐ **Gastrointestinal pathogens panel WITHOUT C diff**☒ **Gastrointestinal pathogens panel WITHOUT C diff by nucleic acid amplification** Frequency: Once

Priority: Routine Specimen Type: Stool

Primary Ordering Comments:

Testing should only be performed on watery or loose stool samples. This is defined as the stool sample that takes the shape of the specimen container. Stool samples which are formed or partially formed will be rejected by the microbiology laboratory.

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

☒ **Discontinue GI panel order if not collected in 3 days** **Frequency:** Until discontinued **Priority:** Routine
Comments: This order only exists to discontinue a GI panel order if it has not been collected in 3 days. There is no action needed from nursing from this order. If the GI panel lab has already been collected, you can discontinue this order.

Primary Ordering Comments:

This order only exists to discontinue a GI panel order if it has not been collected in 3 days.

There is no action needed from nursing from this order. If the GI panel lab has already been collected, you can discontinue this order.

☒ **C. difficile and GI panel testing is not appropriate for one of the reasons below. If you have questions, please call the Microbiology Laboratory at 713-441-0330.**

C. difficile has been ordered or resulted negative in the past 72 hours and patient has recent GI panel order or results.

Patient has received a laxative, enema or medication with laxative effect. C. difficile is not appropriate until laxative medication has been discontinued for 48 hours.

@LAXPRINTGROUP@

@ENEMAPRINTGROUP@

@LASTLAB(ADEN4041PCR,ASTROPCR,CAMPYLOPCR,CRYPTOPCR,CCAYETPCR,AGGECOLIPCR,EHIST

☐ **C. difficile and GI panel testing is not appropriate. If you have questions, please call the Microbiology Laboratory at 713-441-0330.** **Frequency:** Until discontinued **Priority:** Routine
Process Instructions:

Do not use nursing communication for medication or vital sign instructions or parameters

☒ **Enteric precautions**

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

Cardiology
Imaging
CT

☐ **CT Abdomen Pelvis W/WO Contrast (Omnipaque)**

For those with iodine allergies, please order the panel with Read-Cat (barium sulfate).

☒ **CT Abdomen Pelvis W 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 with IV and PO Contrast (Omnipaque)**

For those with iodine allergies, please order the panel with Read-Cat (barium sulfate).

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

☒ **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 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.

☐ **CT Abdomen and Pelvis without IV Contrast (oral only - Read-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**Other Studies****Respiratory**

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

Rehab

Consults

Physician Consults

☐ **Consult Gastroenterology** Frequency: Once Priority: Routine

Question(s):

Provider Group:

Reason for Consult?

Patient/Clinical information communicated?

Patient/clinical information communicated?

To Provider:

Provider Group:

☐ **Consult General Surgery** Frequency: Once Priority: Routine

Question(s):

Provider Group:

Reason for Consult?

Patient/Clinical information communicated?

Patient/clinical information communicated?

To Provider:

Provider Group:

☐ **Consult Colon & Rectal Surgery** Frequency: Once Priority: Routine

Question(s):

Provider Group:

Reason for Consult?

Patient/Clinical information communicated?

Patient/clinical information communicated?

To Provider:

Provider Group:

Ancillary Consults

☐ **Consult to Case Management** Frequency: Once Priority: Routine **Comments:** Discharge planning starting day 1, Goal length of stay is 2 days. Length of stay may be longer than 2 days with Abscess, Fistula, Obstruction, and Perforation of the colon

Question(s):

Consult Reason: ☐ Other specify ☐ Discharge Planning

Specify: Discharge planning starting day 1, Goal length of stay is 2 days. Length of stay may be longer than 2 days with Abscess, Fistula, Obstruction, and Perforation of the colon

Reason for Consult?

Process Instructions:

If Ordering IV antimicrobial therapy, an additional consult to Case Management OPAT order is needed.

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

Question(s):

Reason for Consult:

Reason for Consult?

☐ **Consult PT Eval and Treat** Frequency: Once Priority: Routine **Comments:** If Patient is unable to ambulate

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 Nutrition Services** Frequency: Once Priority: Routine **Comments:** Educate patient/family on Low Residue diet for discharge

Question(s):

Reason For Consult? ☐ Other (Specify)

Specify: Educate patient/family on Low Residue diet for discharge

Purpose/Topic:

Reason for Consult?

Additional Orders

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