**Location:** _____

**Nursing**

**Vital Signs**

- [x] **Vital Signs-Per unit Protocol** **Frequency:** Per unit protocol **Priority:** Routine
- [ ] **Telemetry**
  - [x] **Telemetry monitoring** **Frequency:** Continuous **Frequency Limit:** 48 Hours **Priority:** Routine
    **Question(s):**
    Order: Place in Centralized Telemetry Monitor: EKG Monitoring Only (Telemetry Box)
    Reason for telemetry:
    Can be off of Telemetry for baths? Yes
    Can be off for transport and tests? Yes
  - [x] **Telemetry additional setup information** **Frequency:** Continuous **Frequency Limit:** 48 Hours **Priority:** Routine
    **Question(s):**
    High Heart Rate (BPM): 130.000
    Low Heart Rate(BPM): 50.000
    High PVC's (per minute): 10.000

**Activity**

- [x] **Activity (specify)** **Frequency:** Until discontinued **Priority:** Routine
  **Question(s):**
  Specify: ○ Activity as tolerated

**Nursing**

- [ ] **Intake and output** **Frequency:** Every 8 hours **Priority:** Routine
- [x] **Pneumococcal and influenza vaccine** **Frequency:** Until discontinued **Priority:** Routine
- [x] **Tobacco cessation education** **Frequency:** Once **Priority:** Routine **Comments:** If patient is a current smoker or has smoked in the past 12 months.

**Diet**

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

**Medications**

- [ ] **Antibiotics**

**If history of infection with ESBL-producing organism or recent prolonged treatment with Pip/Tazo or cefepime, consider use of meropenem**

- ○ **ceFEPime 2 g IV + vancomycin IV Pharmacy to Dose Consult**

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

☑ **ceFEPime (MAXIPIME) IV Dose:** 2 g **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 7 Days **Priority:** STAT **Minimum Infusion Duration:** 3.000 Hours
**Question(s):**
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
**Admin Instructions:**
Classification: Broad Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

☑ **Vancomycin IV Pharmacy Consult to Dose** (Required)

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
**Question(s):**
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
**Process Instructions:**
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **Optional IV Antibiotic Addition - tobramycin (TOBREX) 7 mg/kg IV**

☑ **tobramycin (TOBREX) IV Dose:** 7 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
**Question(s):**
Indication: ○ Sepsis of Unknown Source
**Admin Instructions:**
Pharmacy Consult to dose based on renal function

Classification: Narrow Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

☑ **Pharmacy consult to dose tobramycin Frequency:** Until discontinued **Priority:** Routine
**Question(s):**
Which aminoglycoside do you need help dosing? ○ tobramycin
Indication:

☐ **Suspected Anaerobe Coverage: metroNIDAZOLE (FLAGYL) 500 mg IV**

☑ **metroNIDAZOLE (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
**Question(s):**
Indication: ○ Sepsis of Unknown Source
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
**Admin Instructions:**
Classification: Narrow Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

○ **piperacillin-tazobactam (ZOSYN) 4.5 g IV + vancomycin IV Pharmacy to dose Consult**

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

☑ **piperacillin-tazobactam (ZOSYN) IV Dose:** 4.5 g **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 7 Days **Priority:** STAT **Minimum Infusion Duration:** 4.000 Hours
**Question(s):**
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
**Admin Instructions:**
Classification: Broad Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

☑ **Vancomycin IV Pharmacy Consult to Dose** (Required)

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
**Question(s):**
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
**Process Instructions:**
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **Optional IV Antibiotic Addition - tobramycin (TOBREX) 7 mg/kg IV + Pharmacy Consult to Dose**

☑ **tobramycin (TOBREX) 7 mg/kg IVPB Dose:** 7 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
**Question(s):**
Indication: ○ Sepsis of Unknown Source
**Admin Instructions:**
Pharmacy Consult to dose based on renal function

☑ **Pharmacy consult to dose tobramycin Frequency:** Until discontinued **Priority:** STAT
**Question(s):**
Which aminoglycoside do you need help dosing? ○ tobramycin
Indication:

○ **meropenem (MERREM) 500 mg IV + vancomycin IV Pharmacy to Dose Consult**

☑ **meropenem (MERREM) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 6 hours **Priority:** STAT **Minimum Infusion Duration:** 3.000 Hours
**Question(s):**
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
**Admin Instructions:**
Classification: Broad Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

☑ **Vancomycin IV Pharmacy Consult to Dose** (Required)

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
**Question(s):**
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
**Process Instructions:**
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **Optional IV Antibiotic Addition - tobramycin (TOBREX) 7 mg/kg IV**

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

☑ **tobramycin (TOBREX) IV Dose:** 7 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
**Question(s):**
Indication: ○ Sepsis of Unknown Source
**Admin Instructions:**
Pharmacy Consult to dose based on renal function

Classification: Narrow Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

☑ **Pharmacy consult to dose tobramycin Frequency:** Until discontinued **Priority:** Routine
**Question(s):**
Which aminoglycoside do you need help dosing? ○ tobramycin
Indication:

○ **For Patient with Penicillin allergy (PENFAST >3) AND Cephalosporin Allergy - aztreonam IV + vancomycin IV Pharmacy to Dose Consult**
**(i.e. Type 1 immediate hypersensitivity reaction - anaphylaxis, bronchospasm, angioedema, urticaria)**

☑ **aztreonam (AZACTAM) IV Dose:** 2 g **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 7 Days **Priority:** STAT
**Question(s):**
Indication: ○ Respiratory Tract
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
**Admin Instructions:**
Classification: Broad Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

☑ **Vancomycin IV Pharmacy Consult to Dose** (Required)

☑ **Pharmacy consult to manage vancomycin Frequency:** Until discontinued **Priority:** Routine
**Question(s):**
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
**Process Instructions:**
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.

☐ **Optional IV Antibiotic Addition - tobramycin (TOBREX) 7 mg/kg IV**

☑ **tobramycin (TOBREX) IV Dose:** 7 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
**Question(s):**
Indication: ○ Sepsis of Unknown Source
**Admin Instructions:**
Pharmacy Consult to dose based on renal function

Classification: Narrow Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

☑ **Pharmacy consult to dose tobramycin Frequency:** Until discontinued **Priority:** Routine
**Question(s):**
Which aminoglycoside do you need help dosing? ○ tobramycin
Indication:

☐ **Suspected Anaerobe Coverage: metroNIDAZOLE (FLAGYL) 500 mg IV**

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

☑ **metroNIDAZOLE (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
**Question(s):**
Indication: ○ Sepsis of Unknown Source
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
**Admin Instructions:**
Classification: Narrow Spectrum Antibiotic

When multiple antimicrobial agents are ordered, you may administer these immediately at the SAME TIME via different IV sites. Do not wait for the first antibiotic to infuse. If agents are Y-site compatible, they may be administered per Y-site protocols. IF the ordered agents are NOT Y site compatible, then administer the Broad-spectrum antibiotic first. Refer to available Y site compatibility information and determination of broad-spectrum antibiotic selection chart.

**Antipyretics**

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

**Respiratory**

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

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

**Antitussives**

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

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

**Antibacterials**

**Labs**

**Hematology/Coagulation**

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

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

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

☐ **D-dimer, quantitative Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

**Chemistry**

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

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

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

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

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

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

☐ **Blood gas, arterial - STAT Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☐ **Cardiac Labs with Repeat**

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

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

☐ **Troponin T - Q8hrs x 2** **Frequency:** Every 8 hours **Frequency Limit:** 2 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Draw 8 hours after previous troponin levels, if applicable.

☐ **Troponin T - Q8hrs x 3** **Frequency:** Every 8 hours **Frequency Limit:** 3 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Draw 8 hours after previous troponin levels, if applicable.

☐ **Troponin T - Q6hrs x 2** **Frequency:** Every 6 hours **Frequency Limit:** 2 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Draw 6 hours after previous troponin levels, if applicable.

☐ **Troponin T - Q6hrs x 3** **Frequency:** Every 6 hours **Frequency Limit:** 3 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Draw 6 hours after previous troponin levels, if applicable.

☐ **Troponin T - Q4hrs x 2** **Frequency:** Every 4 hours **Frequency Limit:** 2 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Draw 4 hours after previous troponin levels, if applicable.

☐ **Troponin T - Q4hrs x 3** **Frequency:** Every 4 hours **Frequency Limit:** 3 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Draw 4 hours after previous troponin levels, if applicable.

**Urine**

☐ **Streptococcus pneumoniae urinary antigen** **Frequency:** Once **Priority:** Routine **Specimen Type:** Urine

☐ **Legionella antigen, urine** **Frequency:** Once **Priority:** Routine **Specimen Type:** Urine

**Microbiology**

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

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

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

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

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

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

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

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

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

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

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

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

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

@LASTPROCRESULT(LAB462)@

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

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

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

- [x] **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.

- [x] **Sputum culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Sputum **Comments:** C&S; Gram Stain is included in the Sputum Culture. Do not wait to give antibiotics if there is any delay in obtaining a sputum sample.

- [ ] **AFB stain** **Frequency:** Once **Priority:** Routine **Specimen Type:** Sputum

- [ ] **AFB Culture**

  - ○ **AFB Culture to rule out TB (respiratory specimen)**

    - ○ **AFB Culture X 3 (for sputum and tracheal aspirate)**

      - [x] **AFB culture** **Frequency:** Daily **Frequency Limit:** 3 Days **Start Date:** S **Priority:** Routine **Specimen Type:** Sputum
      - [x] **Mycobacterium tuberculosis by PCR** **Frequency:** Once **Priority:** Routine
      - [x] **Airborne isolation status** **Frequency:** Continuous **Priority:** Routine

    - ○ **AFB Culture (for BAL, bronchial brushing and bronchial washing)**

      - [x] **AFB culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Bronchial alveolar lavage
      - [x] **Mycobacterium tuberculosis by PCR** **Frequency:** Once **Priority:** Routine
      - [x] **Airborne isolation status** **Frequency:** Continuous **Priority:** Routine

  - ○ **AFB Culture**

    - [x] **AFB culture** **Frequency:** Once **Priority:** Routine

- [ ] **Respiratory Pathogen Panel with COVID-19** (Required)

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

  - [x] **Isolation** (Required)

    Airborne isolation is recommended for all Confirmed or Suspected COVID-19 patients.

    - [x] **Airborne Isolation**

      - [x] **Airborne isolation status** **Frequency:** Continuous **Priority:** Routine

    - [x] **Contact Isolation**

      - [x] **Contact isolation status** **Frequency:** Continuous **Priority:** Routine

**Cardiology**

**12-Lead ECG**

- [ ] **ECG 12 lead** **Frequency:** Once **Priority:** Routine **Maximum Quantity:** 6

**Question(s):**
Clinical Indications: ○ Shortness of Breath
Interpreting Physician:

**Imaging**

**Diagnostic CT**

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

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

Fasting for this test is not required.

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

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

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

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

**Diagnostic X-Ray**

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

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

**Other Studies**

**Respiratory**

**Rehab**

**Consults**

For Physician Consult orders use sidebar

**Ancillary Consults**

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

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

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

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

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

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

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

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

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

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

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

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

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

**Additional Orders**

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