Location: _____

General

Isolation

☐ **Airborne isolation status**

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

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

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

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

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

Precautions

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

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

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

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

Nursing

Nursing Care

☐ **Insert feeding tube** **Frequency:** Once **Priority:** Routine

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

☐ **Nasogastric tube insert and maintain**

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

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

☐ **Insert and maintain Foley**

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

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

Activity

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

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

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

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

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

Diet

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

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

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

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

IV Fluids

IV Bolus

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

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

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

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

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

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

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

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

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

Maintenance IV Fluids

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

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

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

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

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

Insert and Maintain IV

○ **Initiate and maintain IV**

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

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

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

○ **Insert and Maintain Peripheral IV**

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

☑ **sodium chloride 0.9 % flush Dose:** 3 mL **Frequency:** every 12 hours scheduled

☑ **IV site care Frequency:** Per unit protocol **Priority:** Routine

☑ **sodium chloride 0.9 % flush Dose:** 3 mL **Frequency:** PRN

Medications

Antibiotics

☐ **IV Vancomycin Loading Dose + Pharmacy Consult**

☑ **vancomycin (VANCOCIN) IV Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
Loading Dose

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

☐ **piperacillin-tazobactam (ZOSYN) IV Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
EXTENDED INFUSION Administer over 4 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

☐ **linezolid (ZYVOX) IV Route:** intravenous **Frequency:** every 12 hours **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication:

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

☐ **meropenem (MERREM) IV Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
EXTENDED INFUSION Administer over 3 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

☐ **cefepime (MAXIPIME) IV Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
EXTENDED INFUSION Administer over 3 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

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

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

Antihypertensives

☐ **metoprolol tartrate (LOPRESSOR) tablet Dose:** 25 **Route:** oral **Frequency:** 2 times daily
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:

☐ **metoprolol (LOPRESSOR) injection Dose:** 5 **Route:** intravenous
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Maximum total dose is 15 mg over a 10-15 minute period.

☐ **labetalol (TRANDATE) injection Route:** intravenous **Frequency:** PRN **PRN Reasons:** high blood pressure
Admin Instructions:
Administer if Systolic BP GREATER than ***

☐ **hydrALAZINE (APRESOLINE) injection Dose:** 20 **Route:** intravenous
Question(s):
BP HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Administer if Systolic BP GREATER than ***

Other Medications

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

☐ **hydrocortisone sodium succinate (Solu-CORTEF) injection Dose:** 100 **Route:** intravenous **Frequency:** every 6 hours

☐ **lactulose solution Dose:** .67 G **Route:** oral **Frequency:** 3 times daily

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

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

☐ **norepinephrine (LEVOPHED) injection Dose:** 200 mcg **Route:** intravenous **Frequency:** once

PRN Pain Medications

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

○ **fentaNYL (SUBLIMAZE) injection** **Dose:** 50 mcg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)

○ **morPHINE injection** **Dose:** 4 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)

○ **hydromorPHONE (DILAUDID) injection** **Dose:** 0.8 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)

Pharmacy Consults

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

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

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

See protocol for details

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

☐ **Pharmacy consult to manage TPN therapy** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Enteral Nutrition:
Indication:
Location of venous access:
Is patient volume restricted:
Anticipated duration:
Will patient likely require TPN on discharge?

VTE

Cardiology

Cardiology

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

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

☐ **Echocardiogram 2d complete with contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Does this study require a chemo toxicity strain protocol?
Does this exam need a strain protocol?
Call back number for Critical Findings:
Where should test be performed?
Does this exam need a bubble study?
Preferred interpreting Cardiologist or group:
Process Instructions:
If this patient has had an echocardiogram ordered/performed within the past 120 hours as indicated by repeat Echo orders report on the left. Please contact the Echo department at 713-441-2222 to discuss the reason for a repeat exam with a cardiologist.

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

Other Indications should be ordered for TODAY or Routine.

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

Imaging

CT

☐ **CT Brain**

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

Fasting for this test is not required.

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

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

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

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

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

Fasting for this test is not required.

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

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

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

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

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

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

X-Ray

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

☐ **Chest 1 Vw Portable** **Frequency:** 1 time imaging **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.):

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

☐ **IR PICC Placement** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
What is the expected date for Procedure?
Is the patient pregnant?
What is the patient's sedation requirements?
Physician contact number:
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
Process Instructions:
Patient cannot eat or drink after midnight on the night before the procedure (must be a minimum of 8 hours prior to the procedure). Patient may take small sips of water with his/her usual medications. Please see special instructions below for diabetic patients or
patients currently taking blood-thinners or anti-coagulants.

If patient is allergic to IV contrast medium or iodine or has had an allergic reaction to it in the past, please notify Interventional Radiology staff as soon as possible.

If the patient is diabetic:
Discuss with the patient whether or not to take insulin the morning of the procedure. The patient will not be eating the morning of the exam, so the dosage may need to be altered. For those patients on Metformin, Glucovance, Metaglip or Glucophage, discuss whether it is safe to discontinue these the morning of the procedure.

If the patient is currently taking blood-thinners or anti-coagulants:
Discuss with the patient whether it is safe to discontinue anti-coagulants or blood-thinner medications, including Coumadin, Lovenox, Heparin, Plavix, Aggronox, Arixtra, or Aspirin 5 days prior to the procedure.

The following labs will need to be performed: BUN, Creatinine, PT, PTT, INR, PLT, CBC, BMP.

Other Studies

Respiratory

Respiratory

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

☐ **Suctioning** **Frequency:** As needed **Priority:** Routine
Question(s):
Route:

☐ **IPV -** **Frequency:** Respiratory Therapy - every 4 hours while awake **Priority:** Routine
Question(s):
Medications:

☐ **PEP** **Frequency:** 4 times daily **Priority:** Routine

☐ **Vibratory PEP** **Frequency:** 4 times daily **Priority:** Routine

Rehab

Consults

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

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?

☐ **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?

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

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

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

Additional Orders

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