Location: _____

Enhanced Recovery After Surgery (ERAS) Orders

☐ **ERAS Postop Diet/Nutrition and Multimodal Pain Medications**

☐ **ERAS Diet and Nutrition**

Encourage early return to normal diet (hydration and nourishment); Start or advance diet based on patient's tolerance and disease state

○ **ERAS Diet and Nutrition for Acute patients**

☑ **IMPACT Advanced Recovery** **Frequency:** Daily with meals **Phase of Care:** PACU & Post-op **Priority:** Routine **Comments:** IMPACT Advanced Recovery. Drink 1 carton (6 oz/180 mL) by mouth 2 (two) times daily with meals starting postoperative day 1 for 15 doses. Contraindications: not for individuals with galactosemia deficiency, allergy to fish oil, congential milk protein allergy, rare contraindications with intractable hyperkalemia. Suitable for these diets: lactose intolerance, gluten-free, kosher, halal.
Question(s):
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements: ○ Impact AR
Can/Bottle Supplements: ○ Impact Advance Recovery
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:

☑ **Encourage sips of IMPACT as tolerated** **Frequency:** Until discontinued **Phase of Care:** PACU & Post-op **Priority:** Routine **Comments:** Postop day 0 encourage sips of IMPACT Advanced Recovery nutrition drink as tolerated.

☑ **Diet - Soft easy to digest** **Frequency:** Diet effective now **Priority:** Routine **Comments:** soft
Question(s):
Diet(s): ○ Easy to digest (GERD)
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☑ **Consult to Nutrition Services** **Frequency:** Once **Priority:** Routine
Question(s):
Reason For Consult? ○ Other (Specify)
Specify: ERAS Nutrition Screening
Purpose/Topic: ○ RD to perform nutrition screening and manage ERAS nutrition inluding post-op Impact formula as appropriate
Reason for Consult?

☐ **Chew Gum** **Frequency:** Until discontinued **Priority:** Routine **Comments:** Chew gum 3 times a day (for at least 30 minutes each time) beginning evening of POD # 0.

○ **ERAS Diet and Nutrition for ICU patients**

For patients LESS THAN 65 years old:

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

☑ **IMPACT Advanced Recovery** **Frequency:** Daily with meals **Frequency Limit:** 5 Days **Start Date:** S+1 **Phase of Care:** PACU & Post-op **Priority:** Routine **Comments:** IMPACT Advanced Recovery. Drink 1 carton (6 oz/180 mL) by mouth 2 (two) times daily with meals starting postoperative day 1 for 15 doses. Contraindications: not for individuals with galactosemia deficiency, allergy to fish oil, congential milk protein allergy, rare contraindications with intractable hyperkalemia. Suitable for these diets: lactose intolerance, gluten-free, kosher, halal.
Question(s):
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements: ○ Impact AR
Can/Bottle Supplements: ○ Impact Advance Recovery
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:

☑ **Encourage sips of IMPACT as tolerated** **Frequency:** Until discontinued **Phase of Care:** PACU & Post-op **Priority:** Routine **Comments:** After extubation, Postop day 0, encourage sips of IMPACT Advanced Recovery nutrition drink as tolerated.

☑ **Nursing communication** **Frequency:** Until discontinued **Phase of Care:** PACU & Post-op **Priority:** Routine **Comments:** After extubation, perform bedside swallow evaluation.

☑ **Diet - Full Liquids** **Frequency:** Diet effective now **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Diet(s): ○ Full Liquids
Advance Diet as Tolerated? ○ Yes
Target Diet: GERD - Easy to Digest diet
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☑ **Consult to Nutrition Services** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Reason For Consult? ○ Other (Specify)
Specify: ERAS
Purpose/Topic: ○ RD to manage ERAS nutrition including post-op Impact formula as appropriate
Reason for Consult?

☐ **ERAS Diet and Nutrition**

Encourage early return to normal diet (hydration and nourishment); Start or advance diet based on patient's tolerance and disease state

○ **ERAS Diet and Nutrition for Acute patients**

☑ **Diet - Soft easy to digest** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine **Comments:** soft
Question(s):
Diet(s): ○ Easy to digest (GERD)
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☐ **Chew Gum** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Chew gum 3 times a day (for at least 30 minutes each time) beginning evening of POD # 0.

○ **ERAS Diet and Nutrition for ICU patients**

For patients LESS THAN 65 years old:

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

☑ **Nursing communication** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** After extubation, perform bedside swallow evaluation.

☑ **Diet - Full Liquids** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Diet(s): ○ Full Liquids
Advance Diet as Tolerated? ○ Yes
Target Diet: GERD - Easy to Digest diet
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☐ **ERAS Multimodal Pain Medications**

Goal of ERAS multimodal pain management is to preemptively manage and control postoperative pain and reduce opioid use. Select a combination of scheduled around the clock non-opioid analgesic medications and use opioid only for moderate to severe breakthrough pain (pain score 4-10)

☐ **acetaminophen (TYLENOL)**

Select IV then switch to oral or enteral as scheduled OR select oral or enteral post-op; Do not exceed 4 gms a day/2 gms for cirrhotic patients.

○ **Acetaminophen oral, per tube or rectal panel**

Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

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

◉ **acetaminophen (TYLENOL) suppository** **Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **Acetaminophen oral, per tube or rectal panel**

Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

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

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

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **acetaminophen IV followed by oral**

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

☐ **acetaminophen (TYLENOL)**

○ **Acetaminophen oral, per tube or rectal panel**

Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

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

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **Acetaminophen oral, per tube or rectal panel**

Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

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

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **acetaminophen (OFIRMEV) IV (RESTRICTED) - for patients that cannot tolerate oral/enteral/rectal Dose:** 1000 mg **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 3 Occurrences **Phase of Care:** PACU & Post-op
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
IV acetaminophen (Ofirmev) is restricted to use only in OR, PACU, or ICU areas, and for patients that cannot tolerate oral, per tube, or rectal routes of administration. Do you attest that this restriction has been met?
Allowance for Patient Preference:
Admin Instructions:
IV acetaminophen is restricted to use in patients that cannot tolerate oral, per tube, or rectal routes of administration, and is only approved for post-operative use. If patient status allows, please utilize an alternate route of administration of acetaminophen.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

☐ **Nonsteroidal Anti-inflammatory Drug (NSAID)**

Select Ketorolac(TORADOL) IV and one oral NSAID to follow IV dose OR select one oral NSAID unless contraindicated; Do not give to patients with Stage IV - V CKD or AKI; increases risk of GI bleeding

○ **Ketorolac (TORADOL) IV and one oral NSAID to follow IV dose**

☐ **ketorolac (TORADOL) IV**

○ **ketorolac (TORADOL) 15 mg IV Q6H Dose:** 15 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 15 mg IV Q8H Dose:** 15 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 30 mg IV Q6H Dose:** 30 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 30 mg IV Q8H Dose:** 30 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID.

☑ **Celecoxib (CELEBREX) OR Ibuprofen (MOTRIN) OR Naprosyn Sodium (ALEVE) oral/enteral doses**

○ **celecoxib (CeleBREX) 200 mg Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Do not administer if CrCl < 30 mL/min
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

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

○ **ibuprofen (ADVIL) 400 mg** **Dose:** 400 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 600 mg** **Dose:** 600 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 800 mg** **Dose:** 800 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet** **Dose:** 375 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
DO NOT administer if creatinine > 1 mg/dL and age GREATER than 75 years old
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **Ketorolac (TORADOL) IV and one oral NSAID to follow IV dose**

☐ **ketorolac (TORADOL) IV**

○ **ketorolac (TORADOL) 15 mg IV Q6H** **Dose:** 15 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 15 mg IV Q8H** **Dose:** 15 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 30 mg IV Q6H** **Dose:** 30 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

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

○ **ketorolac (TORADOL) 30 mg IV Q8H** **Dose:** 30 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID.

☑ **Celecoxib (CELEBREX) OR Ibuprofen (MOTRIN) OR Naprosyn Sodium (ALEVE) oral/enteral doses**

○ **celecoxib (CeleBREX) 200 mg** **Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Do not administer if CrCl < 30 mL/min
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 400 mg** **Dose:** 400 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 600 mg** **Dose:** 600 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 800 mg** **Dose:** 800 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet** **Dose:** 375 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
DO NOT administer if creatinine > 1 mg/dL and age GREATER than 75 years old
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **Celecoxib (CELEBREX) OR Ibuprofen (MOTRIN) OR Naprosyn Sodium (ALEVE) oral/enteral doses**

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

○ **celecoxib (CeleBREX) 200 mg Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Do not administer if CrCl < 30 mL/min
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 400 mg Dose:** 400 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 600 mg Dose:** 600 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 800 mg Dose:** 800 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet Dose:** 375 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
DO NOT administer if creatinine > 1 mg/dL and age GREATER than 75 years old
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

☐ **Gabapentinoids**
Consider pregabalin (LYRICA) only if unable to tolerate gabapentin (NEURONTIN)
Contact physician if somnolence or drowsiness persists; Need renal dose adjustment; Do not administer if CrCl < 15 mL/min; Give with caution to patients 65 years of age and older

○ **HM IP MEDICATIONS PREGABALIN ERAS**

○ **Pregabalin for patients GREATER than 65 years old**

○ **pregabalin (LYRICA) capsule 25 mg (CrCl greater than or equal to 60 mL/min) Dose:** 25 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **pregabalin (LYRICA) capsule 25 mg (CrCl 30-59 mL/min) Dose:** 25 mg **Route:** oral **Frequency:** 2 times daily **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

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

○ **pregabalin (LYRICA) capsule 25 mg (CrCl 15-29 mL/min)** **Dose:** 25 mg **Route:** oral **Frequency:** at bedtime **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **Pregabalin for patients LESS than 65 years old**

○ **pregabalin (LYRICA) capsule 50 mg (CrCl greater than or equal to 60 mL/min)** **Dose:** 50 mg **Route:** oral **Frequency:** 3 times daily
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **pregabalin (LYRICA) capsule 50 mg (CrCl 30-59 mL/min)** **Dose:** 50 mg **Route:** oral **Frequency:** 2 times daily
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **pregabalin (LYRICA) capsule 50 mg (CrCl 15-29 mL/min)** **Dose:** 50 mg **Route:** oral **Frequency:** at bedtime
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **HM IP GABAPENTIN POSTOP ACUTE ERAS**

○ **Gabapentin for patients GREATER than 65 years old**

○ **gabapentin (NEURONTIN) capsule 100 mg (CrCl greater than or equal to 60 mL/min)** **Dose:** 100 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 100 mg (CrCl 30-59 mL/min)** **Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 100 mg (CrCl 15-29 mL/min)** **Dose:** 100 mg **Route:** oral **Frequency:** at bedtime **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **Gabapentin for patients LESS than 65 years old**

○ **gabapentin (NEURONTIN) capsule 300 mg (CrCl greater than or equal to 60 mL/min)** **Dose:** 300 mg **Route:** oral **Frequency:** 3 times daily
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 300 mg (CrCl 30-59 mL/min)** **Dose:** 300 mg **Route:** oral **Frequency:** 2 times daily
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 300 mg (CrCl 15-29 mL/min)** **Dose:** 300 mg **Route:** oral **Frequency:** at bedtime
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

☐ **Muscle Relaxant**

○ **Patients GREATER THAN or EQUAL to 65 years old**

☑ **methocarbamol (ROBAXIN) IV followed by oral**

☑ **methocarbamol (ROBAXIN) IVPB** **Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours scheduled **Frequency Limit:** 3 Occurrences

☑ **methocarbamol (ROBAXIN) tablet** **Dose:** 500 mg **Route:** oral **Frequency:** every 6 hours scheduled **Frequency Limit:** 14 Days

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

☐ **cyclobenzaprine (FLEXERIL) tablet Dose:** 5 mg **Route:** oral **Frequency:** every 12 hours scheduled **Frequency Limit:** 3 Days

○ **Patients LESS THAN 65 years old**

☐ **methocarbamol (ROBAXIN) IV followed by oral**

☑ **methocarbamol (ROBAXIN) IVPB Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours scheduled **Frequency Limit:** 3 Occurrences

☑ **methocarbamol (ROBAXIN) tablet Dose:** 500 mg **Route:** oral **Frequency:** every 6 hours scheduled **Frequency Limit:** 14 Days

☐ **cyclobenzaprine (FLEXERIL) tablet Dose:** 5 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 7 Days

☐ **lidocaine (LIDODERM) patch**

☑ **lidocaine (LIDODERM) 5 % Dose:** 1 patch **Route:** transdermal **Frequency:** every 24 hours
Admin Instructions:
Remove after 12 hours (do not give to patients with adhesive sensitivity or allergies to lidocaine).
Product Admin Instructions:
Apply to affected area. Remove patch 12 hours after applying.

☐ **Opioids**

Only for moderate to severe breakthrough pain

☐ **For moderate breakthrough pain (pain score 4-6)**

☐ **oxyCODone (ROXICODONE) immediate release tablet Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Comment:** moderate pain (Non verbal CPOT or pain score 4-6) **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **traMADoL (ULTRAM)**

○ **traMADoL (ULTRAM) tablet - patients with cirrhosis Dose:** 50 mg **Route:** oral **Frequency:** every 12 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **traMADoL (ULTRAM) tablet Dose:** 50 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **For severe breakthrough pain (pain score 7-10)**

☐ **oxyCODone (ROXICODONE) IR - patients LESS than 65 years old Dose:** 10 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **oxyCODONE (ROXICODONE) IR - patients 65 years old and greater Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

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

☐ **traMADol (ULTRAM) tablet Dose:** 100 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **hydromorPHONE (DILAUDID) injection Dose:** 0.2 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
IF unable to tolerate oral intake

☐ **Initiate ERAS**
Use order to initiate ERAS for patients. Follow necessary steps to improve enhanced recovery.

☑ **Post Procedure ERAS Initiation Frequency:** Continuous **Frequency Limit:** 14 Days **Priority:** Routine

☐ **ERAS Postop Diet/Nutrition and Multimodal Pain Medications**

☐ **ERAS Diet and Nutrition**
Encourage early return to normal diet (hydration and nourishment); Start or advance diet based on patient's tolerance and disease state

○ **ERAS Diet and Nutrition for Acute patients**

☑ **Diet - Soft easy to digest Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine **Comments:** soft
Question(s):
Diet(s): ○ Easy to digest (GERD)
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☐ **Chew Gum Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Chew gum 3 times a day (for at least 30 minutes each time) beginning evening of POD # 0.

○ **ERAS Diet and Nutrition for ICU patients**
For patients LESS THAN 65 years old:

☑ **Nursing communication Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** After extubation, perform bedside swallow evaluation.

☑ **Diet - Full Liquids Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Diet(s): ○ Full Liquids
Advance Diet as Tolerated? ○ Yes
Target Diet: GERD - Easy to Digest diet
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☐ **ERAS Diet and Nutrition**
Encourage early return to normal diet (hydration and nourishment); Start or advance diet based on patient's tolerance and disease state

○ **ERAS Diet and Nutrition for Acute patients**

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

☑ **IMPACT Advanced Recovery** **Frequency:** Daily with meals **Phase of Care:** PACU & Post-op **Priority:** Routine **Comments:** IMPACT Advanced Recovery. Drink 1 carton (6 oz/180 mL) by mouth 2 (two) times daily with meals starting postoperative day 1 for 15 doses. Contraindications: not for individuals with galactosemia deficiency, allergy to fish oil, congential milk protein allergy, rare contraindications with intractable hyperkalemia. Suitable for these diets: lactose intolerance, gluten-free, kosher, halal.
Question(s):
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements: ○ Impact AR
Can/Bottle Supplements: ○ Impact Advance Recovery
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:

☑ **Encourage sips of IMPACT as tolerated** **Frequency:** Until discontinued **Phase of Care:** PACU & Post-op **Priority:** Routine **Comments:** Postop day 0 encourage sips of IMPACT Advanced Recovery nutrition drink as tolerated.

☑ **Diet - Soft easy to digest** **Frequency:** Diet effective now **Priority:** Routine **Comments:** soft
Question(s):
Diet(s): ○ Easy to digest (GERD)
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☑ **Consult to Nutrition Services** **Frequency:** Once **Priority:** Routine
Question(s):
Reason For Consult? ○ Other (Specify)
Specify: ERAS Nutrition Screening
Purpose/Topic: ○ RD to perform nutrition screening and manage ERAS nutrition inluding post-op Impact formula as appropriate
Reason for Consult?

☐ **Chew Gum** **Frequency:** Until discontinued **Priority:** Routine **Comments:** Chew gum 3 times a day (for at least 30 minutes each time) beginning evening of POD # 0.

○ **ERAS Diet and Nutrition for ICU patients**

For patients LESS THAN 65 years old:

☑ **IMPACT Advanced Recovery** **Frequency:** Daily with meals **Frequency Limit:** 5 Days **Start Date:** S+1 **Phase of Care:** PACU & Post-op **Priority:** Routine **Comments:** IMPACT Advanced Recovery. Drink 1 carton (6 oz/180 mL) by mouth 2 (two) times daily with meals starting postoperative day 1 for 15 doses. Contraindications: not for individuals with galactosemia deficiency, allergy to fish oil, congential milk protein allergy, rare contraindications with intractable hyperkalemia. Suitable for these diets: lactose intolerance, gluten-free, kosher, halal.
Question(s):
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements: ○ Impact AR
Can/Bottle Supplements: ○ Impact Advance Recovery
Can/Bottle Supplements: ○ Impact Advanced Recovery
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:

☑ **Encourage sips of IMPACT as tolerated** **Frequency:** Until discontinued **Phase of Care:** PACU & Post-op **Priority:** Routine **Comments:** After extubation, Postop day 0, encourage sips of IMPACT Advanced Recovery nutrition drink as tolerated.

☑ **Nursing communication** **Frequency:** Until discontinued **Phase of Care:** PACU & Post-op **Priority:** Routine **Comments:** After extubation, perform bedside swallow evaluation.

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

☑ **Diet - Full Liquids** **Frequency:** Diet effective now **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Diet(s): ○ Full Liquids
Advance Diet as Tolerated? ○ Yes
Target Diet: GERD - Easy to Digest diet
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☑ **Consult to Nutrition Services** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Reason For Consult? ○ Other (Specify)
Specify: ERAS
Purpose/Topic: ○ RD to manage ERAS nutrition including post-op Impact formula as appropriate
Reason for Consult?

☐ **ERAS Multimodal Pain Medications**

Goal of ERAS multimodal pain management is to preemptively manage and control postoperative pain and reduce opioid use. Select a combination of scheduled around the clock non-opioid analgesic medications and use opioid only for moderate to severe breakthrough pain (pain score 4-10)

☐ **acetaminophen (TYLENOL)**

Select IV then switch to oral or enteral as scheduled OR select oral or enteral post-op; Do not exceed 4 gms a day/2 gms for cirrhotic patients.

○ **Acetaminophen oral, per tube or rectal panel**

Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

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

◉ **acetaminophen (TYLENOL) suppository** **Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **Acetaminophen oral, per tube or rectal panel**

Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

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

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

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **acetaminophen IV followed by oral**

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

☐ **acetaminophen (TYLENOL)**

○ **Acetaminophen oral, per tube or rectal panel**

Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

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

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

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **Acetaminophen oral, per tube or rectal panel**

Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

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

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
fever
Admin Instructions:
Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **acetaminophen (OFIRMEV) IV (RESTRICTED) - for patients that cannot tolerate oral/enteral/rectal Dose:** 1000 mg **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 3 Occurrences **Phase of Care:** PACU & Post-op
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
IV acetaminophen (Ofirmev) is restricted to use only in OR, PACU, or ICU areas, and for patients that cannot tolerate oral, per tube, or rectal routes of administration. Do you attest that this restriction has been met?
Allowance for Patient Preference:
Admin Instructions:
IV acetaminophen is restricted to use in patients that cannot tolerate oral, per tube, or rectal routes of administration, and is only approved for post-operative use. If patient status allows, please utilize an alternate route of administration of acetaminophen.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

☐ **Nonsteroidal Anti-inflammatory Drug (NSAID)**
Select Ketorolac(TORADOL) IV and one oral NSAID to follow IV dose OR select one oral NSAID unless contraindicated; Do not give to patients with Stage IV - V CKD or AKI; increases risk of GI bleeding

○ **Ketorolac (TORADOL) IV and one oral NSAID to follow IV dose**

☐ **ketorolac (TORADOL) IV**

○ **ketorolac (TORADOL) 15 mg IV Q6H Dose:** 15 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 15 mg IV Q8H Dose:** 15 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 30 mg IV Q6H Dose:** 30 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 30 mg IV Q8H Dose:** 30 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID.

☑ **Celecoxib (CELEBREX) OR Ibuprofen (MOTRIN) OR Naprosyn Sodium (ALEVE) oral/enteral doses**

○ **celecoxib (CeleBREX) 200 mg Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Do not administer if CrCl < 30 mL/min
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

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

○ **ibuprofen (ADVIL) 400 mg** **Dose:** 400 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 600 mg** **Dose:** 600 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 800 mg** **Dose:** 800 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet** **Dose:** 375 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
DO NOT administer if creatinine > 1 mg/dL and age GREATER than 75 years old
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **Ketorolac (TORADOL) IV and one oral NSAID to follow IV dose**

☐ **ketorolac (TORADOL) IV**

○ **ketorolac (TORADOL) 15 mg IV Q6H** **Dose:** 15 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 15 mg IV Q8H** **Dose:** 15 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

○ **ketorolac (TORADOL) 30 mg IV Q6H** **Dose:** 30 mg **Route:** intravenous **Frequency:** every 6 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID

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

○ **ketorolac (TORADOL) 30 mg IV Q8H Dose:** 30 mg **Route:** intravenous **Frequency:** every 8 hours
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Then switch to oral NSAID.

☑ **Celecoxib (CELEBREX) OR Ibuprofen (MOTRIN) OR Naprosyn Sodium (ALEVE) oral/enteral doses**

○ **celecoxib (CeleBREX) 200 mg Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Do not administer if CrCl < 30 mL/min
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 400 mg Dose:** 400 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 600 mg Dose:** 600 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 800 mg Dose:** 800 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet Dose:** 375 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
DO NOT administer if creatinine > 1 mg/dL and age GREATER than 75 years old
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **Celecoxib (CELEBREX) OR Ibuprofen (MOTRIN) OR Naprosyn Sodium (ALEVE) oral/enteral doses**

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

○ **celecoxib (CeleBREX) 200 mg Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Do not administer if CrCl < 30 mL/min
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 400 mg Dose:** 400 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 600 mg Dose:** 600 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 800 mg Dose:** 800 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet Dose:** 375 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
DO NOT administer if creatinine > 1 mg/dL and age GREATER than 75 years old
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

☐ **Gabapentinoids**
Consider pregabalin (LYRICA) only if unable to tolerate gabapentin (NEURONTIN)
Contact physician if somnolence or drowsiness persists; Need renal dose adjustment; Do not administer if CrCl < 15 mL/min; Give with caution to patients 65 years of age and older

○ **HM IP MEDICATIONS PREGABALIN ERAS**

○ **Pregabalin for patients GREATER than 65 years old**

○ **pregabalin (LYRICA) capsule 25 mg (CrCl greater than or equal to 60 mL/min) Dose:** 25 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **pregabalin (LYRICA) capsule 25 mg (CrCl 30-59 mL/min) Dose:** 25 mg **Route:** oral **Frequency:** 2 times daily **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

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

○ **pregabalin (LYRICA) capsule 25 mg (CrCl 15-29 mL/min)** **Dose:** 25 mg **Route:** oral **Frequency:** at bedtime **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **Pregabalin for patients LESS than 65 years old**

○ **pregabalin (LYRICA) capsule 50 mg (CrCl greater than or equal to 60 mL/min)** **Dose:** 50 mg **Route:** oral **Frequency:** 3 times daily
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **pregabalin (LYRICA) capsule 50 mg (CrCl 30-59 mL/min)** **Dose:** 50 mg **Route:** oral **Frequency:** 2 times daily
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **pregabalin (LYRICA) capsule 50 mg (CrCl 15-29 mL/min)** **Dose:** 50 mg **Route:** oral **Frequency:** at bedtime
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **HM IP GABAPENTIN POSTOP ACUTE ERAS**

○ **Gabapentin for patients GREATER than 65 years old**

○ **gabapentin (NEURONTIN) capsule 100 mg (CrCl greater than or equal to 60 mL/min)** **Dose:** 100 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 100 mg (CrCl 30-59 mL/min)** **Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 100 mg (CrCl 15-29 mL/min)** **Dose:** 100 mg **Route:** oral **Frequency:** at bedtime **Frequency Limit:** 5 Days
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **Gabapentin for patients LESS than 65 years old**

○ **gabapentin (NEURONTIN) capsule 300 mg (CrCl greater than or equal to 60 mL/min)** **Dose:** 300 mg **Route:** oral **Frequency:** 3 times daily
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 300 mg (CrCl 30-59 mL/min)** **Dose:** 300 mg **Route:** oral **Frequency:** 2 times daily
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **gabapentin (NEURONTIN) capsule 300 mg (CrCl 15-29 mL/min)** **Dose:** 300 mg **Route:** oral **Frequency:** at bedtime
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

☐ **Muscle Relaxant**

○ **Patients GREATER THAN or EQUAL to 65 years old**

☑ **methocarbamol (ROBAXIN) IV followed by oral**

☑ **methocarbamol (ROBAXIN) IVPB** **Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours scheduled **Frequency Limit:** 3 Occurrences

☑ **methocarbamol (ROBAXIN) tablet** **Dose:** 500 mg **Route:** oral **Frequency:** every 6 hours scheduled **Frequency Limit:** 14 Days

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

☐ **cyclobenzaprine (FLEXERIL) tablet Dose:** 5 mg **Route:** oral **Frequency:** every 12 hours scheduled **Frequency Limit:** 3 Days

○ **Patients LESS THAN 65 years old**

☐ **methocarbamol (ROBAXIN) IV followed by oral**

☑ **methocarbamol (ROBAXIN) IVPB Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours scheduled **Frequency Limit:** 3 Occurrences

☑ **methocarbamol (ROBAXIN) tablet Dose:** 500 mg **Route:** oral **Frequency:** every 6 hours scheduled **Frequency Limit:** 14 Days

☐ **cyclobenzaprine (FLEXERIL) tablet Dose:** 5 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 7 Days

☐ **lidocaine (LIDODERM) patch**

☑ **lidocaine (LIDODERM) 5 % Dose:** 1 patch **Route:** transdermal **Frequency:** every 24 hours
Admin Instructions:
Remove after 12 hours (do not give to patients with adhesive sensitivity or allergies to lidocaine).
Product Admin Instructions:
Apply to affected area. Remove patch 12 hours after applying.

☐ **Opioids**

Only for moderate to severe breakthrough pain

☐ **For moderate breakthrough pain (pain score 4-6)**

☐ **oxyCODone (ROXICODONE) immediate release tablet Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Comment:** moderate pain (Non verbal CPOT or pain score 4-6) **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **traMADoL (ULTRAM)**

○ **traMADoL (ULTRAM) tablet - patients with cirrhosis Dose:** 50 mg **Route:** oral **Frequency:** every 12 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **traMADoL (ULTRAM) tablet Dose:** 50 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **For severe breakthrough pain (pain score 7-10)**

☐ **oxyCODone (ROXICODONE) IR - patients LESS than 65 years old Dose:** 10 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **oxyCODONE (ROXICODONE) IR - patients 65 years old and greater Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

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

☐ **traMADol (ULTRAM) tablet Dose:** 100 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **hydromorPHONE (DILAUDID) injection Dose:** 0.2 mg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
IF unable to tolerate oral intake

General

Common Present on Admission Diagnosis

☐ **Acidosis Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Acute Post-Hemorrhagic Anemia Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Acute Renal Failure Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Acute Respiratory Failure Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Acute Thromboembolism of Deep Veins of Lower Extremities Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Anemia Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Bacteremia Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Bipolar disorder, unspecified Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Cardiac Arrest Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Cardiac Dysrhythmia Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Cardiogenic Shock Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Decubitus Ulcer Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Dementia in Conditions Classified Elsewhere Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Disorder of Liver Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Electrolyte and Fluid Disorder Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Intestinal Infection due to Clostridium Difficile Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Methicillin Resistant Staphylococcus Aureus Infection Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Obstructive Chronic Bronchitis with Exacerbation Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Other Alteration of Consciousness Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Other and Unspecified Coagulation Defects Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Other Pulmonary Embolism and Infarction Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Phlebitis and Thrombophlebitis Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Protein-calorie Malnutrition Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Psychosis, unspecified psychosis type Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Schizophrenia Disorder Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Sepsis Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Septic Shock Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Septicemia Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Type II or Unspecified Type Diabetes Mellitus with Mention of Complication, Not Stated as Uncontrolled Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Urinary Tract Infection, Site Not Specified Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

Elective Outpatient, Observation, or Admission

○ **Elective outpatient procedure: Discharge following routine recovery Frequency:** Continuous **Phase of Care:** PACU & Post-op **Priority:** Routine

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

◯ **Outpatient observation services under general supervision** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

◯ **Outpatient in a bed - extended recovery** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

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

Admission or Observation

Patient has active outpatient status order on file

◯ **Admit to Inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** PACU & Post-op **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 **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

◯ **Outpatient in a bed - extended recovery** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

◯ **Transfer patient** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Level of Care:
Bed request comments:

◯ **Return to previous bed** **Frequency:** Until discontinued **Phase of Care:** Scheduling/ADT **Priority:** Routine

Admission

Patient has active status order on file

◯ **Admit to inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** PACU & Post-op **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.

◯ **Transfer patient** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Level of Care:
Bed request comments:

◯ **Return to previous bed** **Frequency:** Until discontinued **Phase of Care:** Scheduling/ADT **Priority:** Routine

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

Transfer

Patient has active inpatient status order on file

○ **Transfer patient** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Level of Care:
Bed request comments:

○ **Return to previous bed** **Frequency:** Until discontinued **Phase of Care:** Scheduling/ADT **Priority:** Routine

Code Status

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

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

○ **Full code** **Frequency:** Continuous **Priority:** Routine
Question(s):
Code Status decision reached by:

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

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

☐ **Consult to Palliative Care Service**

☑ **Consult to Palliative Care Service** **Frequency:** Once **Priority:** Routine
Question(s):
Priority:
Reason for Consult?
Order?
Name of referring provider:
Enter call back number:
Reason for Consult?
Process Instructions:
Note: Please call Palliative care office 832-522-8391. Due to current resource constraints, consultation orders received after 2:00 pm M-F will be seen the following business day. Consults placed over weekend will be seen on Monday.

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

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

☐ **Treatment Restrictions ((For use when a patient is NOT in a cardiopulmonary arrest))** **Frequency:** Continuous - Treatment Restrictions **Phase of Care:** Post-op **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 **Phase of Care:** Post-op **Priority:** Routine

☐ **Droplet isolation status** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Enteric isolation status** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

Precautions

☐ **Aspiration precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Fall precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Increased observation level needed:

☐ **Latex precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Seizure precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Increased observation level needed:

Nursing

Vital Signs

☑ **Vital signs - T/P/R/BP Per Unit Protocol** **Frequency:** Per unit protocol **Phase of Care:** Post-op **Priority:** Routine

☐ **Telemetry**

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

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

Activity

☑ **Activity as tolerated** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Specify: ○ Activity as tolerated

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

☐ **Head of bed 30 degrees** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** If not contraindicated
Question(s):
Head of bed: ○ 30 degrees

☐ **Bed rest** **Frequency:** Until discontinued **Frequency Limit:** 24 Hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** Evening of surgery
Question(s):
Bathroom Privileges:

☐ **Up in chair for meals** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Specify: ○ Up in chair
Additional modifier: for meals

☐ **Ambulate POD 1** **Frequency:** 3 times daily **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Specify: ○ in hall ○ with assistance

Nursing Care

☐ **Measure drainage** **Frequency:** Every 8 hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** Record output from drain every 8 hours and as needed
Question(s):
Type of drain:

☑ **Intake and Output** **Frequency:** Every 8 hours **Phase of Care:** Post-op **Priority:** Routine

☑ **Saline lock IV** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine **Comments:** When tolerating soft or regular diet

☐ **Bladder scan** **Frequency:** As needed **Phase of Care:** Post-op **Priority:** Routine **Comments:** If patient does not void within 4 hours of urinary catheter removal, bladder scan and notify surgical team.

Tubes and Drain Care

☐ **Drain care** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Empty and record as it fills or Q12H if minimal output.
Question(s):
Drain 1:
Drain 2:
Drain 3:
Drain 4:
All Drains:

☐ **Remove Foley catheter** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Do not remove Foley** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Rationale:

☐ **Nasogastric tube insertion** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Type:

☑ **Nasogastric tube maintenance** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Tube Care Orders: ○ To Low Intermittent Suction

☐ **Gastric tube maintenance** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Drainage:
Intervention:

☐ **Jejunostomy tube maintenance** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Drainage:
Intervention:

Incision/Wound Care

☐ **Abdominal binder** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Waking hours only?
Nurse to schedule?
Special Instructions:

☑ **Surgical/incision site care** **Frequency:** Daily **Phase of Care:** Post-op **Priority:** Routine **Comments:** Removed surgical dressing POD 2. After removal, wound, tube, and drain care every day and as needed. Notify MD/NP if any concern of erythema/drainage.
Question(s):
Location:
Site:
Apply:
Dressing Type:
Open to air?

☐ **Wound care orders** **Frequency:** Every 12 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Location:
Site:
Irrigate wound?
Apply:
Dressing Type:
Process Instructions:
This Nursing Order is NOT for a CONSULT for PT Wound Care or WOC nurse. The order is not transmitted to any department.

Do NOT use this order to request :
Bedside debridement, Ultrasound Therapy, Pulsed Lavage, Negative Pressure Vacuum Therapy, Compression therapy, WOC ongoing wound /ostomy management and teaching.

☐ **Provide equipment / supplies at bedside** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Supplies:

☐ **Consult to Wound Ostomy Care Nurse** **Frequency:** Once **Phase of Care:** Post-op **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.

Notify

☑ **Notify Physician for vitals:** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Systolic BP greater than: 160
Systolic BP less than: ○ 110 ○ 90
MAP less than: ○ 60 ○ 60.000
Heart rate greater than (BPM): 100
Heart rate less than (BPM): 60
Respiratory rate greater than: ○ 30 ○ 25
Respiratory rate less than: ○ 10 ○ 8
SpO2 less than: 92
Temperature greater than: 100.5
Temperature less than:
Diastolic BP greater than: 100
Diastolic BP less than: 50

☑ **Notify Physician if urine output is less than:** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** 30 milliliters/hour or less than 250 milliliters/8 hours

☑ **Notify Surgeon** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** And perform bladder scan if patient does not void within 4 hours of urinary catheter removal removal.

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

☑ **Notify Physician for Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Saturated surgical dressing, active bleeding, or change in condition

Education

☐ **Patient education- Activity Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Review Patient Activity Guidelines with patient and family
Question(s):
Patient/Family: ○ Both
Education for: ○ Activity

☐ **Patient education- Wound/Incision Care Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Patient/Family: ○ Both
Education for: ○ Other (specify)
Specify: Wound/Incision Care

☑ **Patient education- Discharge Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Review discharge instructions with patient and family and provide a copy to patient
Question(s):
Patient/Family: ○ Both
Education for: ○ Discharge

IV Fluids

Maintenance IV Fluids

☐ **dextrose 5 % and sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion Dose:** 100 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☐ **lactated Ringer's infusion Dose:** 100 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☐ **sodium chloride 0.9 % infusion Dose:** 100 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☐ **sodium chloride 0.9 % with potassium chloride 20 mEq/L infusion Dose:** 100 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☐ **sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion Dose:** 100 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

Medications

Antibiotics

☐ **piperacillin-tazobactam (ZOSYN) IV Dose:** 4.5 g **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 24 Hours **Phase of Care:** Post-op **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.

☐ **IV Vancomycin - Medical/Surgical Prophylaxis**

☐ **Medical Prophylaxis - 24 hours Dose:** 15 mg/kg **Route:** intravenous **Frequency:** every 12 hours **Frequency Limit:** 24 Hours **Priority:** STAT
Question(s):
Indication: ○ Medical Prophylaxis
Medical Prophylaxis: The maximum duration of therapy that can be entered at this time is 56 days. Order can be renewed if required at that time.
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Pharmacy to automatically adjust frequency to q24h for CrCl < 45ml/min

☐ **Medical Prophylaxis - 72 hours Dose:** 15 mg/kg **Route:** intravenous **Frequency:** every 12 hours **Frequency Limit:** 72 Hours **Priority:** STAT
Question(s):
Indication: ○ Medical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Pharmacy to automatically adjust frequency to q24h for CrCl < 45ml/min

☐ **Vancomycin IV**

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

Patient Weight	Vancomycin Dose
<80 kg	1 g
80-100 kg	1.5 g
>100 kg	2 g

*Maximum pre-op dose 2 g

- [x] **Weight < 80 kg**
  - [x] **Weight < 80 kg Dose:** 1 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
  Priority: STAT
  Question(s):
  Indication: ○ Surgical Prophylaxis
  Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
  Admin Instructions:
  Administer within 120 minutes of incision; On Call to OR
- [x] **Weight 80-100 kg**
  - [x] **Weight 80-100 kg Dose:** 1.5 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
  Priority: STAT
  Question(s):
  Indication: ○ Surgical Prophylaxis
  Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
  Admin Instructions:
  Administer within 120 minutes of incision; On Call to OR
- [x] **Weight >100 KG**
  - [x] **Weight 80-100 kg Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
  Priority: STAT
  Question(s):
  Indication: ○ Surgical Prophylaxis
  Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
  Admin Instructions:
  Administer within 120 minutes of incision; On Call to OR

- [ ] **Post-Operative Surgical Prophylaxis - 1 Dose Dose:** 15 mg/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Surgical Prophylaxis: Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Pharmacy to automatically adjust dose based on pre-operative administration and renal function

- [ ] **Post-Operative Surgical Prophylaxis - 24 hours Dose:** 15 mg/kg **Route:** intravenous **Frequency:** every 12 hours **Frequency Limit:** 24 Hours **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Surgical Prophylaxis: Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Pharmacy to automatically adjust dose based on pre-operative administration and renal function

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

☐ **meropenem (MERREM) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 6 hours **Frequency Limit:** 24 Hours **Phase of Care:** Post-op **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.

☐ **fluconazole (DIFLUCAN) IV Dose:** 200 mg **Route:** intravenous **Frequency:** daily **Frequency Limit:** 7 Days **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication:
Product Admin Instructions:
May cause QTc prolongation.

☐ **metronidazole (FLAGYL) Dose:** 500 mg **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 7 Days **Phase of Care:** Post-op **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:

☐ **ciprofloxacin (CIPRO) IV Dose:** 400 mg **Route:** intravenous **Frequency:** every 12 hours **Frequency Limit:** 7 Days **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Product Admin Instructions:
May cause QTc prolongation.

Stress Ulcer Prophylaxis

○ **pantoprazole (PROTONIX) EC tablet Dose:** 40 mg **Route:** oral **Frequency:** daily **Phase of Care:** Post-op
Question(s):
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
If nasogastric tube is placed.

○ **pantoprazole (PROTONIX) 40 mg in sodium chloride 0.9 % 10 mL injection Dose:** 40 mg **Route:** intravenous **Frequency:** daily **Phase of Care:** Post-op
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
If nasogastric tube is placed.

○ **pantoprazole (PROTONIX) 2 mg/ml oral suspension Dose:** 40 mg **Route:** oral **Frequency:** daily **Phase of Care:** Post-op
Question(s):
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
If nasogastric tube is placed.

○ **omeprazole (PRILOSEC) suspension Dose:** 20 mg **Route:** oral **Frequency:** daily **Phase of Care:** Post-op
Question(s):
Indication(s) for Proton Pump Inhibitor (PPI) Therapy:
Admin Instructions:
Separate administration with all other oral medications by 1 hour.

Beta Blockers

○ **labetalol (NORMODYNE) tablet Dose:** 100 **Frequency:** 2 times daily **Phase of Care:** Post-op
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:

○ **labetalol (NORMODYNE,TRANDATE) injection Phase of Care:** Post-op
Admin Instructions:
Administer if Systolic BP GREATER than ***

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

○ **metoprolol tartrate (LOPRESSOR) tablet** **Dose:** 25 mg **Route:** oral **Frequency:** 2 times daily **Start Date:** S+1 **Phase of Care:** Post-op
Question(s):
BP & HR HOLD parameters for this order: ○ Hold Parameters requested
Contact Physician if:
Admin Instructions:
DO NOT administer if heart rate is less than 60; systolic blood pressure is less than 110; patient is on inotrope, vasopressor, has pacemaker

○ **metoprolol (LOPRESSOR) 5 mg/5 mL injection** **Dose:** 5 **Phase of Care:** Post-op
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.

Antiemetics - HMH, HMSJ, HMW, HMCCH HMTW Only

☑ **ondansetron (ZOFRAN) IV or Oral** (Required)

◉ **ondansetron ODT (ZOFRAN-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 (ZOFRAN) 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 (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

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

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

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

Antiemetics - HMSL, HMWB, HMCY Only

☑ **ondansetron (ZOFRAN) IV or Oral** (Required)

◉ **ondansetron ODT (ZOFRAN-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 (ZOFRAN) 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) IV or Oral or Rectal**

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

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

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

Antiemetics - HMSTJ Only

☑ **ondansetron (ZOFRAN) IV or Oral** (Required)

◉ **ondansetron ODT (ZOFRAN-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 (ZOFRAN) 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) IVPB or Oral or Rectal**

◉ **promethazine (PHENERGAN) 25 mg in sodium chloride 0.9 % 50 mL IVPB Dose:** 12.5 mg **Route:** intravenous **Frequency:** every 6 hours PRN **Minimum Infusion Duration:** 30.000 Minutes **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if ondansetron (ZOFRAN) is ineffective and patient is UNable to tolerate oral or rectal medication OR if a faster onset of action is required.

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

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

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

Bowel Care

☐ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per tablet Dose:** 2 tablet **Route:** oral **Frequency:** nightly PRN **Phase of Care:** Post-op **PRN Reasons:** constipation

☐ **simethicone (MYLICON) chewable tablet Dose:** 160 mg **Route:** oral **Frequency:** 4 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** flatulence

☐ **docusate sodium (COLACE) capsule Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** constipation

☐ **magnesium hydroxide suspension - NOT RECOMMENDED FOR CHRONIC KIDNEY DISEASE STAGE 3 OR GREATER Dose:** 30 mL **Route:** oral **Frequency:** every 12 hours PRN **Phase of Care:** Post-op **PRN Reasons:** constipation
Admin Instructions:
Do not give if patient is on hemodialysis or is in chronic renal failure.

☐ **bisacodyl (DULCOLAX) EC tablet Dose:** 10 mg **Route:** oral **Frequency:** daily PRN **Phase of Care:** Post-op **PRN Reasons:** constipation

☐ **bisacodyl (DULCOLAX) suppository Dose:** 10 mg **Route:** rectal **Frequency:** daily PRN **Phase of Care:** Post-op **PRN Reasons:** constipation

Itching: For Patients GREATER than 77 years old

○ **cetirizine (ZyrTEC) tablet Dose:** 5 mg **Route:** oral **Frequency:** daily PRN **Phase of Care:** Post-op **PRN Reasons:** itching

Itching: For Patients between 70-76 years old

○ **cetirizine (ZyrTEC) tablet Dose:** 5 mg **Route:** oral **Frequency:** daily PRN **Phase of Care:** Post-op **PRN Reasons:** itching

Itching: For Patients LESS than 70 years old

○ **diphenhydrAMINE (BENADRYL) tablet Dose:** 25 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** itching

○ **hydrOXYzine (ATARAX) tablet Dose:** 10 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** itching

○ **cetirizine (ZyrTEC) tablet Dose:** 5 mg **Route:** oral **Frequency:** daily PRN **Phase of Care:** Post-op **PRN Reasons:** itching

○ **fexofenadine (ALLEGRA) tablet - For eGFR LESS than 80 mL/min, reduce frequency to once daily as needed Dose:** 60 mg **Route:** oral **Frequency:** 2 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** itching

Insomnia: Ramelteon For Patients GREATER than 70 years old

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

Insomnia: For Patients LESS than 70 years old

☐ **zolpidem (AMBIEN) or ramelteon (ROZEREM) tablet nightly PRN sleep**

○ **zolpidem (AMBIEN) tablet Dose:** 5 mg **Route:** oral **Frequency:** nightly PRN **PRN Reasons:** sleep

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

VTE

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 encourgae early ambulation ○ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

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

☑ **Moderate Risk** (Required)

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

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

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

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

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

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

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

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

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

Patient renal status: @CRCL@

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

○ **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:

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

○ **High Bleed Risk**

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

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 - 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 **Phase of Care:** PACU & Post-op **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
Phase of Care: PACU & Post-op
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

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

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

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

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

○ **aspirin chewable tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

○ **aspirin (ECOTRIN) enteric coated tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

○ **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
Phase of Care: PACU & Post-op
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

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

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

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

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

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

VTE Risk and Prophylaxis Tool

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

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

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

○ **LOW Risk of VTE** (Required)

☑ **Low Risk** (Required)

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

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

☑ **Moderate Risk** (Required)

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

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

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

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

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

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

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

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

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

Patient renal status: @CRCL@

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

○ **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:

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

○ **High Bleed Risk**

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

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 - 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 **Phase of Care:** PACU & Post-op **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
Phase of Care: PACU & Post-op
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

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

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

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

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

○ **aspirin chewable tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

○ **aspirin (ECOTRIN) enteric coated tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

○ **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
Phase of Care: PACU & Post-op
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

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

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

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

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

Labs

Labs Today

☑ **CBC with Platelet and Differential Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Prothrombin time with INR Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Basic metabolic panel Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Magnesium level Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

- [x] **Phosphorus level** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [x] **Hepatic function panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [ ] **CBC with platelet and differential NOW AND IN 6 HOURS** **Frequency:** Every 6 hours **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [ ] **Partial thromboplastin time** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
  Primary Ordering Comments:
  Do not draw blood from the arm that has heparin infusion. Do not draw from heparin flushed lines. If there is no other access other than the heparin line, then stop the heparin, flush the line, and aspirate 20 ml of blood to waste prior to drawing a specimen.
- [ ] **Comprehensive metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [ ] **LDH** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Labs Recurring x 7 Start POD 1

- [x] **CBC with Platelet and Differential** **Frequency:** AM draw repeats **Frequency Limit:** 7 Days **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [x] **Prothrombin time with INR** **Frequency:** AM draw repeats **Frequency Limit:** 7 Days **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [x] **Basic metabolic panel** **Frequency:** AM draw repeats **Frequency Limit:** 7 Days **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [x] **Magnesium level** **Frequency:** AM draw repeats **Frequency Limit:** 7 Days **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [x] **Phosphorus level** **Frequency:** AM draw repeats **Frequency Limit:** 7 Days **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [x] **Hepatic function panel** **Frequency:** AM draw repeats **Frequency Limit:** 7 Days **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [ ] **Comprehensive metabolic panel** **Frequency:** AM draw repeats **Frequency Limit:** 7 Days **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [ ] **LDH** **Frequency:** AM draw repeats **Frequency Limit:** 7 Days **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Labs Every Monday x 3

- [ ] **C-reactive protein** **Frequency:** Every Monday **Frequency Limit:** 3 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [ ] **Prealbumin level** **Frequency:** Every Monday **Frequency Limit:** 3 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Arterial Blood Gas

- [ ] **Arterial blood gas ONCE POD 1** **Frequency:** Once **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Cardiology

Imaging

X-Ray

- [x] **XR Chest 1 Vw Portable** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **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.):
- [x] **XR Abdomen 1 Vw Portable** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **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

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

Respiratory

☑ **Incentive spirometry instructions** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Frequency of use: ○ 10 times every hour

☑ **Encourage deep breathing and coughing** **Frequency:** Every 2 hours **Phase of Care:** Post-op **Priority:** Routine

☑ **Oxygen therapy** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Initial Device: ○ Nasal Cannula
Initial Rate in liters per minute: 2 Lpm
Titrate FiO2 to keep O2 Sat Above: 92%
Device:
SpO2 Goal:
SpO2 Goal:
Titrate FiO2 to keep O2 saturations:
Notify Physician if:
Indications for O2 therapy:
Indications for O2 therapy:
Primary Ordering Comments:
@CERMSG(661071:25704)@

Rehab

Consults

For Physician Consult orders use sidebar

Ancillary Consults

☑ **Consult to PT eval and treat** **Frequency:** Once **Phase of Care:** Post-op **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 Case Management** **Frequency:** Once **Phase of Care:** Post-op **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 **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for Consult:
Reason for Consult?

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

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

☐ **Consult OT eval and treat** **Frequency:** Once **Phase of Care:** Post-op **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 **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason For Consult?
Purpose/Topic:
Reason for Consult?

☐ **Consult to Spiritual Care** **Frequency:** Once **Phase of Care:** Post-op **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 **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for consult:
Reason for SLP?

☐ **Consult to Wound Ostomy Care nurse** **Frequency:** Once **Phase of Care:** Post-op **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 **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for Consult?
Reason for Consult?

Additional Orders

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