

Location: _____

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
- ☐ **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:

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

☐ **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

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:

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

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

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**Vitals**

☒ **Vital signs - T/P/R/BP** Frequency: Per unit protocol Start Date: S Phase of Care: Post-op Priority: Routine Comments: On arrival and then routine

Activity

☒ **Head of bed** Frequency: Until discontinued Phase of Care: Post-op Priority: Routine

Question(s):

Head of bed: ☐ 30 degrees

☒ **Strict bed rest** Frequency: Until discontinued Frequency Limit: 24 Hours Start Date: S Phase of Care: Post-op Priority: Routine Comments: For 24 hours PostOp

☒ **Up in chair** Frequency: Until discontinued Start Date: S+1 Phase of Care: Post-op Priority: Routine Comments: Starting 24 hours post-operative.

Question(s):

Specify: ☐ Up in chair

Nursing

☒ **Insert feeding tube** Frequency: Once Frequency Limit: 1 Occurrences Phase of Care: Post-op Priority: Routine Comments: Insert Dobhoff tube

☒ **Strict intake and output** Frequency: Every 8 hours Phase of Care: Post-op Priority: Routine Comments: Per floor protocol

☒ **Foley catheter care** Frequency: Until discontinued Phase of Care: Post-op Priority: Routine

Question(s):

Orders: ☐ Maintain ☐ to gravity

☒ **Nasogastric tube maintenance** Frequency: Until discontinued Frequency Limit: -1 Phase of Care: Post-op Priority: Routine Comments: Remove after extubation.

Question(s):

Tube Care Orders: ☐ To Low Intermittent Suction

☐ **Orogastric tube maintenance** Frequency: Until discontinued Phase of Care: Post-op Priority: Routine Comments: Remove after extubation

Question(s):

Tube Care Orders: ☐ To Low Intermittent Suction

☒ **Apply warming blanket** Frequency: As needed Phase of Care: Post-op Priority: Routine Comments: As needed to raise body temperature to 98.6 Fahrenheit

☒ **Reinforce dressing** Frequency: As needed Phase of Care: Post-op Priority: Routine Comments: Reinforce dressing as needed.

Question(s):

Reinforce with:

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

☒ **Hemodynamic Monitoring** Frequency: Every hour Phase of Care: Post-op Priority: Routine

Question(s):

Measure: ☐ Other

Other: Swan Ganz to monitor, Recalibrate SV02 every morning. Record SV02 every 1 hour. DO NOT WEDGE SWAN.

☒ **Chest tube to continuous suction** Frequency: Until discontinued Phase of Care: Post-op Priority: Routine Comments:

Chest tube to 20 centimeter water pressure.

Question(s):

Level of suction: 20 cm H2O

☒ **Neurological assessment** Frequency: Daily Phase of Care: Post-op Priority: Routine

Question(s):

Assessment to Perform:

☒ **Hold sedation every morning coordinated with CV intensivist to assess neurological status** Frequency: Until discontinued Frequency Limit: -1 Phase of Care: Post-op Priority: Routine

☒ **All blood products must be irradiated and leukocyte reduced** Frequency: Until discontinued Phase of Care: Post-op Priority: Routine

☐ **Blood products must be CMV negative if donor and recipients are CMV negative** Frequency: Until discontinued Phase of Care: Post-op Priority: Routine

Notify Physician

☒ **Notify Physician for vitals:** Frequency: Until discontinued Phase of Care: Post-op Priority: Routine Comments: Contact Pulmonary Transplant Service/Page 713-441-2215 upon patient arrival to floor, and for any questions. Page 713-441-2215 if shortness of breath, critical labs, vomiting, GI bleed, cardiac arrhythmias, or chest pain.

Question(s):

Temperature greater than: ☐ 100.1 ☐ 100.5

Systolic BP greater than: 160

Systolic BP less than: 90

Diastolic BP greater than: ☐ 110 ☐ 100

Diastolic BP less than: ☐ 40 ☐ 50

MAP less than: ☐ 60 ☐ 60.000

Heart rate greater than (BPM): ☐ 120 ☐ 100

Heart rate less than (BPM): ☐ 50 ☐ 60

Respiratory rate greater than: 25

Respiratory rate less than: 8

SpO2 less than: ☐ 88 ☐ 92

Temperature less than:

☒ **Notify CV Intensivist for critical labs, vomiting, GI bleed, cardiac arrhythmias, chest pain** Frequency: Until discontinued Phase of Care: Post-op Priority: Routine

☒ **CV Intensivist if chest tube drainage greater than 100 millimeters in 2 hours.** Frequency: Until discontinued Phase of Care: Post-op Priority: Routine

Diet

☒ **NPO** Frequency: Diet effective now Start Date: S Phase of Care: Post-op Priority: Routine

Question(s):

NPO:

Pre-Operative fasting options:

Process Instructions:

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

IV Fluids

IV Fluids

☐ **sodium chloride 0.9 % bolus** Dose: 500 mL Route: intravenous Frequency: once Frequency Limit: 1 Occurrences Phase of Care: Post-op Minimum Infusion Duration: 30.000 Minutes

☐ **sodium chloride 0.9 % infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous Phase of Care: Post-op

☐ **sodium chloride 0.45 % infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous Phase of Care: Post-op

☐ **dextrose 5%-0.45% sodium chloride infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous Phase of Care: Post-op

☐ **dextrose 5%-0.9% sodium chloride infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous Phase of Care: Post-op

☐ **sodium chloride 0.9 % with potassium chloride 20 mEq/L infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous Phase of Care: Post-op

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

- ☐ **dextrose 5 % and sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous Phase of Care: Post-op
- ☐ **dextrose 5 % and sodium chloride 0.9 % with potassium chloride 20 mEq/L infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous Phase of Care: Post-op
- ☐ **sodium chloride 0.45 % 1,000 mL with sodium bicarbonate 75 mEq/L infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous Phase of Care: Post-op

Medications**Pharmacy Consult**

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

Restricted Medications

- ☒ **No ketorolac (Toradol)** Frequency: Until discontinued Phase of Care: Post-op Priority: STAT
- Question(s):**
Reason for "No" order: ☐ Transplant patient
- ☒ **No NSAIDs EXcluding aspirin** Frequency: Until discontinued Phase of Care: Post-op Priority: STAT
- Question(s):**
Reason for "No" order: ☐ Post-Lung Transplant

Induction Therapy

- ☒ **basiliximab (SIMULECT) IVPB - POD #4** Dose: 20 mg Frequency: once Frequency Limit: 1 Occurrences Start Date: S+4 Start Time: 1100 Phase of Care: Post-op
- Admin Instructions:**
Administer on POD #4

Immunosuppressants (Required)

- ☒ **Immunosuppression Therapy: Option 1 - methylPREDNISolone and predniSONE (Required)**
- ☒ **methylPREDNISolone (Solu-MEDROL) IV Push - POD #1 and 2** Dose: 2 mg/kg Route: intravenous Frequency: daily Frequency Limit: 2 Occurrences Start Date: S+1 Phase of Care: Post-op
- ☒ **methylPREDNISolone (Solu-MEDROL) IV Push - POD #3 and 4** Dose: 1.5 mg/kg Route: intravenous Frequency: daily Frequency Limit: 2 Occurrences Start Date: S+3 Phase of Care: Post-op
- ☒ **methylPREDNISolone (Solu-MEDROL) IV Push - POD #5 and 6** Dose: 1 mg/kg Route: intravenous Frequency: daily Frequency Limit: 2 Occurrences Start Date: S+5 Phase of Care: Post-op
- ☒ **predniSONE (DELTASONE) tablet - POD #7 and 8** Dose: 40 mg Route: oral Frequency: daily Frequency Limit: 2 Occurrences Start Date: S+7 Phase of Care: Post-op
- Product Admin Instructions:**
Give with food or snacks.
- ☒ **predniSONE (DELTASONE) tablet - POD #9 and 10** Dose: 20 mg Route: oral Frequency: daily Frequency Limit: 2 Occurrences Start Date: S+9 Phase of Care: Post-op
- Product Admin Instructions:**
Give with food or snacks.
- ☒ **predniSONE (DELTASONE) tablet - POD #11** Dose: 10 mg Route: oral Frequency: daily Start Date: S+11 Phase of Care: Post-op
- Product Admin Instructions:**
Give with food or snacks.
- ☒ **Immunosuppression Therapy: Option 3 - mycophenolate IVPB (Required)**
- ☒ **HM RX IP MYCOPHENOLATE IV AND NS BAG FOR LINE CARE PANEL**
- ☒ **mycophenolate (CELLCEPT) in dextrose 5% IVPB** Frequency: 2 times daily at 0900, 2100 (TIME CRITICAL)
- ☒ **sodium chloride 0.9 % bag for line care** Dose: .9 Frequency: PRN Minimum Infusion Rate: 30.000 mL/hr
- PRN Reasons:** line care
Admin Instructions:
For mycophenolate line care

- ☐ **Immunosuppression Therapy: Option 1 - tacrolimus NG Tube or Oral and cyclosporine NG Tube or Oral**

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

☐ **tacrolimus (PROGRAF) 0.5 mg/ml oral suspension - POD #1** Dose: .5 Route: Nasogastric Frequency: 2 times daily at 0600, 1800 (TIME CRITICAL) Start Date: S+1 Phase of Care: Post-op

Admin Instructions:

Clamp Nasogastric tube times 1 hour.

Product Admin Instructions:

May cause QTc prolongation.

☐ **tacrolimus (PROGRAF) capsule - POD #1** Dose: .5 Route: sublingual Frequency: 2 times daily at 0600, 1800 Start Date: S+1 Phase of Care: Post-op

Admin Instructions:

Open the capsule and put the contents under the tongue.

Product Admin Instructions:

May cause QTc prolongation.

☐ **cycloSPORINE (NEORAL) solution - POD #1** Dose: 100 Route: Nasogastric Frequency: 2 times daily at 0600, 1800 Start Date: S+1 Phase of Care: Post-op

Admin Instructions:

Clamp Nasogastric tube times 1 hour.

☐ **cycloSPORINE (NEORAL) capsule - POD #1** Dose: 25 Route: oral Frequency: 2 times daily at 0600, 1800 Start Date: S+1 Phase of Care: Post-op

Admin Instructions:

do not crush, split, or chew

Pneumocystis Prophylaxis

☐ **sulfamethoxazole-trimethoprim (BACTRIM DS) Options**

☐ **sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg tablet** Dose: 800-160 Frequency: user specified

Question(s):

Indication: ☐ Medical Prophylaxis

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☒ **sulfamethoxazole-trimethoprim (BACTRIM) 200-40 mg/5 mL suspension** Dose: 200-40 Frequency: user specified

Question(s):

Indication: ☐ Medical Prophylaxis

☐ **atovaquone (MEPRON) suspension - If Known or Suspected Sulfa Allergy - POD #5** Dose: 750 mg Route: Nasogastric Frequency: 2 times daily Start Date: S+5

Admin Instructions:

If Known or Suspected Sulfa Allergy

Antivirals

☐ **valGANCiclovir (VALCYTE) 50 mg/mL oral solution** Dose: 450 mg Route: oral Frequency: 2 times daily Phase of Care: Post-op

Question(s):

Indication: ☐ Medical Prophylaxis

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

☒ **ganciclovir (CYTOVENE) IV plus sodium chloride 0.9% bag for line care**

☒ **ganciclovir (CYTOVENE) IVPB**

Question(s):

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

Indication:

☒ **sodium chloride 0.9 % bag for line care** Dose: .9 Frequency: PRN Minimum Infusion Rate: 100.000 mL/hr PRN

Reasons: line care

Admin Instructions:

For Ganciclovir line care: program sodium chloride bag to run as the same rate as medication. Allow at least 30 minutes post infusion to account for line-flushing.

☐ **acyclovir (ZOVIRAX) IV** Dose: 5 mg/kg Route: intravenous Frequency: every 8 hours Phase of Care: Post-op 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.:

Indication:

☐ **acyclovir (ZOVIRAX)** Dose: 200 mg Route: oral Frequency: 2 times daily Phase of Care: Post-op

Question(s):

Indication: ☐ Medical Prophylaxis

Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

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

Antifungal

☒ **nystatin (MYCOSTATIN) 100,000 unit/mL suspension** Dose: 5 mL Route: oral Frequency: 4 times daily Phase of Care:

Post-op

Question(s):

Indication: ☐ Surgical Prophylaxis

Admin Instructions:

Paint mouth with swab while intubated. Once extubated, convert to swish and swallow.

Product Admin Instructions:

Swish in mouth

☒ **voriconazole (VFEND) 200 mg/5 mL suspension** Dose: 200 mg Route: Nasogastric Frequency: every 12 hours Phase of

Care: Post-op

Question(s):

Indication: ☐ Medical Prophylaxis

Admin Instructions:

Hold tube feeds for 1 hour pre- and 1 hour post-administration

Product Admin Instructions:

May cause QTc prolongation.

☒ **micafungin (MYCAMINE) IVPB** Dose: 100 mg Route: intravenous Frequency: every 24 hours Frequency Limit: 2

Occurrences Phase of Care: Post-op Priority: STAT Minimum Infusion Duration: 1.000 Hours

Question(s):

RESTRICTED to Infectious Diseases (ID), Solid Organ Transplant (SOT), Bone Marrow Transplant (BMT), and Hematology/Oncology (Heme/Onc) specialists. Are you an ID, SOT, BMT, or Heme/Onc specialist or ordering on behalf of one? YES, I am an approved provider

Indication: ☐ Surgical Prophylaxis

RESTRICTED to Infectious Diseases (ID), Solid Organ Transplant (SOT), Bone Marrow Transplant (BMT), and Hematology/Oncology (Heme/Onc) specialists. Are you an ID, SOT, BMT, or Heme/Onc specialist or ordering on behalf of one?

☒ **ipratropium (ATROVENT) 0.02 % nebulizer solution followed by amphotericin B liposome (AMBISOME) 50 mg inhalation suspension**

☒ **ipratropium (ATROVENT) 0.02 % nebulizer solution** Dose: 0.5 mg Route: nebulization Frequency: user specified

Question(s):

Aerosol Delivery Device: ☐ Hand-Held Nebulizer

☒ **amphotericin B liposome (AMBISOME) inhalation suspension** Dose: 50 mg Route: inhalation Frequency: user specified

Admin Instructions:

For inhalation use only

PostOperative Antibiotics - Gram Positive coverage (Required)☒ **Gram Positive Coverage Antibiotics**

☒ **vancomycin (VANCOCIN) IV - Administer 1 hour PRIOR to skin incision.** Dose: 15 mg/kg Route: intravenous Frequency: every 12 hours Frequency Limit: 7 Days Phase of Care: Post-op 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.:

Indication:

☐ **linezolid in dextrose 5% (ZYVOX) IVPB - For Known/Suspected Allergies or Suspected Drug-Resistant Organism to Vancomycin** Dose: 600 mg Route: intravenous Frequency: every 12 hours Frequency Limit: 7 Days Phase of Care:

Post-op Priority: STAT

Question(s):

Indication: Medical Prophylaxis

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

Indication:

PostOperative Antibiotics - Gram Negative coverage (Required)☒ **Gram Negative Coverage Antibiotics (Required)**

Select ONE of the following:

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

☒ **ceFEPime (MAXIPIME) IV** Dose: 2 g Route: intravenous Frequency: every 8 hours Frequency Limit: 7 Days Phase of Care: Post-op 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:

****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.

☐ **piperacillin-tazobactam (ZOSYN) IV** Dose: 4.5 g Route: intravenous Frequency: every 8 hours Frequency Limit: 7 Days Phase of Care: Post-op 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:

****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.

☐ **meropenem (MERREM) IV** Dose: 500 mg Route: intravenous Frequency: every 6 hours Frequency Limit: 7 Days Phase of Care: Post-op 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:

****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.

☐ **For Penicillin Allergy: aztreonam (AZACTAM) IV** Dose: 2 g Route: intravenous Frequency: every 8 hours Frequency Limit: 7 Days Phase of Care: Post-op 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:

For Known or Suspected Penicillin Allergy

PostOperative Antibiotics – Mycoplasma/Ureaplasma coverage (Required)

☒ **Doxycycline (Vibramycin) IV** Dose: 100 mg Route: intravenous Frequency: every 12 hours Frequency Limit: 7 Days Phase of Care: Post-op Priority: STAT

Question(s):

Indication: ○ Surgical Prophylaxis

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

Stress Ulcer Prophylaxis

☐ **pantoprazole (PROTONIX) injection** Dose: 40 mg Route: intravenous Frequency: daily at 0600 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:

☐ **famotidine (PEPCID) injection** Dose: 20 mg Route: intravenous Frequency: 2 times 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 H2 Receptor Antagonist (H2RA) Therapy:

PRN Mild Pain (Pain Score 1-3)**(adjust dose for renal/liver function and age)**

☐ **acetaminophen (TYLENOL) tablet OR oral suspension**

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)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient able to take oral tablet medication.

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)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient cannot receive oral tablet but can receive oral solution.

**PRN Oral for Moderate Pain (Pain Score 4-6): For Patients LESS than 65 years old
(adjust dose for renal/liver function and age)**

☐ **acetaminophen-codeine (TYLENOL #3) tablet OR oral solution**

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

☒ **acetaminophen-codeine (TYLENOL #3) 300-30 mg per tablet** Dose: 1 tablet Route: oral Frequency: every 6 hours PRN PRN Reasons: moderate pain (score 4-6)

Question(s):

The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication.

☒ **acetaminophen-codeine 300 mg-30 mg /12.5 mL solution** Dose: 12.5 mL Route: oral Frequency: every 6 hours PRN PRN Reasons: moderate pain (score 4-6)

Question(s):

The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:

Allowance for Patient Preference:

Admin Instructions:

Use if patient cannot swallow tablet.

☐ **HYDROcodone-acetaminophen 5/325 (NORCO) tablet OR elixir**

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

☒ **HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet** Dose: 1 tablet 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.

☒ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution** Dose: 10 mL Route: oral Frequency: every 6 hours PRN PRN Reasons: moderate pain (score 4-6)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

If patient cannot swallow tablet.

☐ **HYDROcodone-acetaminophen 7.5/325 (NORCO) tablet OR elixir**

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

☒ **HYDROcodone-acetaminophen (NORCO) 7.5-325 mg per tablet** Dose: 1 tablet Route: oral Frequency: every 6 hours PRN PRN Reasons: moderate pain (score 4-6)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication.

Product Admin Instructions:

Give if patient can receive oral tablet/capsule.

☒ **HYDROcodone-acetaminophen (HYCET) 7.5-325 mg/15 mL solution** Dose: 15 mL Route: oral Frequency: every 6 hours PRN PRN Reasons: moderate pain (score 4-6)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Use if patient cannot swallow tablet.

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

- ☐ **HYDROcodone-acetaminophen 10/325 (NORCO) tablet OR elixir**

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

- ☒ **HYDROcodone-acetaminophen (NORCO 10-325) mg per tablet** Dose: 1 tablet Route: oral Frequency: every 6 hours

PRN Phase of Care: Post-op PRN Reasons: moderate pain (score 4-6)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication.

- ☒ **HYDROcodone-acetaminophen (HYCET) 7.5-325 mg/15 mL solution** Dose: 20 mL Route: oral Frequency: every 6

hours PRN Phase of Care: Post-op PRN Reasons: moderate pain (score 4-6)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Use if patient can not swallow tablet.

- ☐ **traMADol (ULTRAM) tablet - For eGFR LESS than 30 mL/min, change frequency to every 12 hours** Dose: 50 mg

Route: oral Frequency: every 6 hours PRN Phase of Care: Post-op PRN Reasons: moderate pain (score 4-6)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

(Max Daily dose not to exceed 200 mg/day).

Give if patient is able to tolerate oral medication

Product Admin Instructions:

Give if patient can receive oral tablet/capsule.

PRN Oral for Moderate Pain (Pain Score 4-6): For Patients GREATER than 65 years old

NOTICE: Before any pain medication is used you MUST NOTIFY MD and get approval.

(adjust dose for renal/liver function and age)

- ☐ **acetaminophen-codeine (TYLENOL #3) tablet OR oral solution**

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

- ☒ **acetaminophen-codeine (TYLENOL #3) 300-30 mg per tablet** Dose: 1 tablet Route: oral Frequency: every 6 hours

PRN PRN Reasons: moderate pain (score 4-6)

Question(s):

The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication.

- ☒ **acetaminophen-codeine 300 mg-30 mg /12.5 mL solution** Dose: 12.5 mL Route: oral Frequency: every 6 hours

PRN PRN Reasons: moderate pain (score 4-6)

Question(s):

The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:

Allowance for Patient Preference:

Admin Instructions:

Use if patient cannot swallow tablet.

- ☐ **HYDROcodone-acetaminophen 5/325 (NORCO) tablet OR elixir**

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

- ☒ **HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet** Dose: 1 tablet 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.

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

☒ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution** Dose: 10 mL Route: oral Frequency: every 6 hours PRN PRN Reasons: moderate pain (score 4-6)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

If patient cannot swallow tablet.

☐ **traMADol (ULTRAM) tablet - For eGFR LESS than 30 mL/min, change frequency to every 12 hours** Dose: 25 mg Route: oral Frequency: every 6 hours PRN Phase of Care: Post-op PRN Reasons: moderate pain (score 4-6)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

(Max Daily dose not to exceed 200 mg/day). Give if patient can tolerate oral medication.

Product Admin Instructions:

Give if patient can receive oral tablet/capsule.

PRN IV for Moderate Pain (Pain Score 4-6): For Patients LESS than 65 years old

If you select a PCA option you will not be allowed to also order IV PRN pain medications from this section.

(adjust dose for renal/liver function and age)

☐ **fentaNYL (SUBLIMAZE) injection** Dose: 25 mcg Route: intravenous Frequency: every 2 hour PRN Phase of Care: Post-op PRN Reasons: moderate pain (score 4-6)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

☐ **morphine 2 mg/mL injection** Dose: 2 mg Route: intravenous Frequency: every 3 hours PRN Phase of Care: Post-op PRN Reasons: moderate pain (score 4-6)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

☐ **HYDROmorphine (DILAUDID) injection** Dose: 0.5 mg Route: intravenous Frequency: every 3 hours PRN Phase of Care: Post-op PRN Reasons: moderate pain (score 4-6)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

PRN IV for Moderate Pain (Pain Score 4-6): For Patients GREATER than 65 years old

If you select a PCA option you will not be allowed to also order IV PRN pain medications from this section.

(adjust dose for renal/liver function and age)

☐ **fentaNYL (SUBLIMAZE) injection** Dose: 12.5 mcg Route: intravenous Frequency: every 2 hour PRN Phase of Care: Post-op PRN Reasons: moderate pain (score 4-6)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

☐ **morphine 2 mg/mL injection** Dose: 1 mg Route: intravenous Frequency: every 3 hours PRN Phase of Care: Post-op PRN Reasons: moderate pain (score 4-6)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

☐ **HYDROmorphine (DILAUDID) injection** Dose: 0.2 mg Route: intravenous Frequency: every 3 hours PRN Phase of Care: Post-op PRN Reasons: moderate pain (score 4-6)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

PRN Oral for Severe Pain (Pain Score 7-10): For Patients LESS than 65 years old

(adjust dose for renal/liver function and age)

☐ **HYDROmorphine (DILAUDID) tablet** Dose: 2 mg Route: oral Frequency: every 6 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication

Product Admin Instructions:

Give if patient can receive oral tablet/capsule.

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

☐ **morphine (MSIR) tablet** Dose: 15 mg Route: oral Frequency: every 6 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication

Product Admin Instructions:

Give if patient can receive oral tablet/capsule. Do not crush, split, or chew.

☐ **oxyCODONE (ROXICODONE) immediate release tablet** Dose: 10 mg Route: oral Frequency: every 6 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication

Product Admin Instructions:

Give if patient can receive oral tablet/capsule.

PRN Oral for Severe Pain (Pain Score 7-10): For Patients GREATER than 65 years old

(adjust dose for renal/liver function and age)

☐ **HYDROcodone-acetaminophen (NORCO) 7.5-325 mg per tablet** Dose: 1 tablet Route: oral Frequency: every 6 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication

Product Admin Instructions:

Give if patient can receive oral tablet/capsule.

☐ **HYDROcodone-acetaminophen (NORCO 10-325) 10-325 mg per tablet** Dose: 1 tablet Route: oral Frequency: every 6 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication

☐ **HYDROmorphine (DILAUDID) tablet** Dose: 2 mg Route: oral Frequency: every 6 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication

Product Admin Instructions:

Give if patient can receive oral tablet/capsule.

☐ **morphine (MSIR) tablet** Dose: 15 mg Route: oral Frequency: every 6 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication

Product Admin Instructions:

Give if patient can receive oral tablet/capsule. Do not crush, split, or chew.

☐ **oxyCODONE (ROXICODONE) immediate release tablet** Dose: 5 mg Route: oral Frequency: every 6 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Give if patient is able to tolerate oral medication

Product Admin Instructions:

Give if patient can receive oral tablet/capsule.

PRN IV for Severe Pain (Pain Score 7-10): For Patients LESS than 65 years old

If you select a PCA option you will not be allowed to also order IV PRN pain medications from this section.
(adjust dose for renal/liver function and age)

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

☐ **fentaNYL (SUBLIMAZE) injection** Dose: 50 mcg Route: intravenous Frequency: every 3 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

☐ **morphine injection** Dose: 4 mg Route: intravenous Frequency: every 3 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

☐ **HYDROmorphine (DILAUDID) injection** Dose: 0.8 mg Route: intravenous Frequency: every 3 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

PRN IV for Severe Pain (Pain Score 7-10): For Patients GREATER than 65 years old

If you select a PCA option you will not be allowed to also order IV PRN pain medications from this section. (adjust dose for renal/liver function and age)

☐ **fentaNYL (SUBLIMAZE) injection** Dose: 25 mcg Route: intravenous Frequency: every 3 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

☐ **morphine injection** Dose: 2 mg Route: intravenous Frequency: every 3 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

☐ **HYDROmorphine (DILAUDID) injection** Dose: 0.5 mg Route: intravenous Frequency: every 3 hours PRN Phase of Care: Post-op PRN Reasons: severe pain (score 7-10)

Admin Instructions:

Use if patient is unable to swallow or faster onset is needed

Bowel Care

☒ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per tablet** Dose: 1 tablet Route: oral Frequency: 2 times daily Phase of Care: Post-op

Admin Instructions:

Hold for diarrhea.

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

☒ **polyethylene glycol (MIRALAX) packet** Dose: 17 g Route: oral Frequency: daily PRN Phase of Care: Post-op PRN Reasons: constipation

Product Admin Instructions:

Mix in 4-8oz of water.

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

Antiemetics

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

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

Admin Instructions:

Give if patient is able to tolerate oral medication.

Product Admin Instructions:

May cause QTc prolongation.

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

Admin Instructions:

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

Product Admin Instructions:

May cause QTc prolongation.

☐ **promethazine (PHENERGAN)**

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

☒ **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.

Respiratory Medications

☐ **albuterol (PROVENTIL) nebulizer solution** Dose: 2.5 mg Route: nebulization Frequency: Respiratory Therapy - every 4 hours Frequency Limit: 7 Days Phase of Care: Post-op PRN Reasons: wheezing
shortness of breath

Question(s):

Aerosol Delivery Device:

☒ **ipratropium (ATROVENT) 0.02 % nebulizer solution** Dose: 0.5 mg Route: nebulization Frequency: Respiratory Therapy - every 6 hours Frequency Limit: 7 Days Phase of Care: Post-op

Question(s):

Aerosol Delivery Device:

☒ **acetylcysteine 200 mg/mL (20%) inhalation solution** Dose: 200 Route: nebulization Frequency: Respiratory Therapy - every 12 hours Phase of Care: Post-op

Question(s):

Aerosol Delivery Device: o Hand-Held Nebulizer

Admin Instructions:

Patients should receive an aerosolized bronchodilator 10 to 15 minutes prior to dose

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

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

Insomnia: For Patients GREATER than 70 years old

☐ **ramelteon (ROZEREM) tablet** Dose: 8 mg Route: oral Frequency: nightly PRN Phase of Care: Post-op 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

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

VTE

VTE Risk and Prophylaxis Tool (Required)

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

Anticoagulation Guide for COVID patients ([https://formweb.com/files/houstonmethodist/documents/COVID-19 Anticoagulation Guideline - 8.20.2021v15.pdf](https://formweb.com/files/houstonmethodist/documents/COVID-19%20Anticoagulation%20Guideline%20-%208.20.2021v15.pdf))

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

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

- ☐ **Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Required)**
- ☒ **Moderate risk of VTE** Frequency: Once Priority: Routine
- ☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Frequency: Once Priority: Routine
- Question(s):**
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:
- ☒ **Place sequential compression device**
- ☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine
- Question(s):**
No mechanical VTE prophylaxis due to the following contraindication(s):
- ☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine
- Question(s):**
Side: Bilateral
Select Sleeve(s):
- ☐ **Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Required)**
- ☒ **Moderate risk of VTE** Frequency: Once Priority: Routine
- ☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Frequency: Once Priority: Routine
- Question(s):**
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:
- ☒ **Place sequential compression device**
- ☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine
- Question(s):**
No mechanical VTE prophylaxis due to the following contraindication(s):
- ☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine
- Question(s):**
Side: Bilateral
Select Sleeve(s):
- ☐ **High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Required)**
- ☒ **High risk of VTE** Frequency: Once Priority: Routine
- ☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Frequency: Once Priority: Routine
- Question(s):**
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:
- ☒ **Place sequential compression device**
- ☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine
- Question(s):**
No mechanical VTE prophylaxis due to the following contraindication(s):
- ☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine
- Question(s):**
Side: Bilateral
Select Sleeve(s):
- ☐ **High Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Required)**
- ☒ **High risk of VTE** Frequency: Once Priority: Routine
- ☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Frequency: Once Priority: Routine
- Question(s):**
No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:
- ☒ **Place sequential compression device**

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

☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

☐ **LOW Risk of VTE (Required)**

☒ **Low Risk (Required)**

☒ **Low risk of VTE** Frequency: Once Priority: Routine

Question(s):

Low risk: ☐ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation ☐ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

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

☒ **Moderate Risk (Required)**

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

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

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

☒ **Contraindications exist for pharmacologic prophylaxis** Frequency: Once Priority: Routine

Question(s):

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **Contraindications exist for pharmacologic prophylaxis** Frequency: Once Priority: Routine

Question(s):

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

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

Patient renal status: @CRCL@

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

☒ **enoxaparin (LOVENOX) injection** Dose: 30 mg Route: subcutaneous Frequency: daily at 1700

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** Route: subcutaneous Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** Dose: 2.5 mg Route: subcutaneous Frequency: daily Start Date: S+1

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

☐ **High Bleed Risk**

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

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

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

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

☐ **Not high bleed risk**

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

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

☐ **warfarin (COUMADIN)**

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

☐ **WITHOUT pharmacy consult** Dose: 1 Route: oral Frequency: daily at 1700

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Frequency: Until discontinued Priority:

Routine

Question(s):

Indication:

☐ **warfarin (COUMADIN) tablet** Dose: 1 Route: oral

Question(s):

Indication:

Dose Selection Guidance:

☒ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

☐ **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 $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

- ☐ **HEParin (porcine) injection - Q12 Hours** Dose: 5000 Units **Frequency:** every 12 hours scheduled
- ☐ **HEParin (porcine) injection - Q8 Hours** Dose: 5000 Units **Frequency:** every 8 hours scheduled
- ☐ **Not high bleed risk**
- ☐ **Wt > 100 kg** Dose: 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled
- ☐ **Wt LESS than or equal to 100 kg** Dose: 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

☐ **warfarin (COUMADIN)**

- ☐ **WITHOUT pharmacy consult** Dose: 1 **Route:** oral **Frequency:** daily at 1700

Question(s):

Indication:

Dose Selection Guidance:

- ☐ **Medications**

- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** **Frequency:** Until discontinued **Priority:**

Routine

Question(s):

Indication:

- ☐ **warfarin (COUMADIN) tablet** Dose: 1 **Route:** oral

Question(s):

Indication:

Dose Selection Guidance:

☒ **Mechanical Prophylaxis (Required)**

- ☐ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

- ☒ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

☐ **HIGH Risk of VTE - 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 $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

- ☐ **HEParin (porcine) injection - Q12 Hours** Dose: 5000 Units **Frequency:** every 12 hours scheduled
- ☐ **HEParin (porcine) injection - Q8 Hours** Dose: 5000 Units **Frequency:** every 8 hours scheduled
- ☐ **Not high bleed risk**
- ☐ **Wt > 100 kg** Dose: 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled
- ☐ **Wt LESS than or equal to 100 kg** Dose: 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

☐ **warfarin (COUMADIN)**

- ☐ **WITHOUT pharmacy consult** Dose: 1 **Route:** oral **Frequency:** daily at 1700

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** **Frequency:** Until discontinued **Priority:**

Routine

Question(s):

Indication:

- ☐ **warfarin (COUMADIN) tablet** Dose: 1 **Route:** oral

Question(s):

Indication:

Dose Selection Guidance:

☒ **Mechanical Prophylaxis (Required)**

- ☐ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

- ☒ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **High Risk (Required)**

- ☒ **High risk of VTE** **Frequency:** Once **Priority:** Routine

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

- ☐ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine

Question(s):

No pharmacologic VTE prophylaxis due to the following contraindication(s):

- ☐ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical (Required)**

Patient renal status: @CRCL@

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

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

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

☐ ENOXAPARIN 30 MG DAILY

☒ **enoxaparin (LOVENOX) injection** Dose: 30 mg Route: subcutaneous Frequency: daily at 1700
Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ ENOXAPARIN SQ DAILY

☒ **enoxaparin (LOVENOX) injection** Route: subcutaneous Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** Dose: 2.5 mg Route: subcutaneous Frequency: daily

Admin Instructions:

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

☐ heparin

High Risk Bleeding Characteristics

Age $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ High Bleed Risk

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

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

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

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

☐ Not high bleed risk

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

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

☐ warfarin (COUMADIN)

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

☐ **WITHOUT pharmacy consult** Dose: 1 Route: oral Frequency: daily at 1700

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Frequency: Until discontinued Priority:

Routine

Question(s):

Indication:

☐ **warfarin (COUMADIN) tablet** Dose: 1 Route: oral

Question(s):

Indication:

Dose Selection Guidance:

☒ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **High Risk (Required)**

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

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

☐ **Contraindications exist for pharmacologic prophylaxis** Frequency: Once Priority: Routine

Question(s):

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☐ **aspirin chewable tablet** Dose: 162 mg Frequency: daily Start Date: S+1 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 $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

- ☐ **HEParin (porcine) injection - Q12 Hours** Dose: 5000 Units Frequency: every 12 hours scheduled
- ☐ **HEParin (porcine) injection - Q8 Hours** Dose: 5000 Units Frequency: every 8 hours scheduled
- ☐ **Not high bleed risk**
- ☐ **Wt > 100 kg** Dose: 7500 Units Route: subcutaneous Frequency: every 8 hours scheduled
- ☐ **Wt LESS than or equal to 100 kg** Dose: 5000 Units Route: subcutaneous Frequency: every 8 hours scheduled
- ☐ **Rivaroxaban and Pharmacy Consult (Required)**
- ☒ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission** Dose: 10 mg Frequency: daily at 0600 (TIME CRITICAL)
- Question(s):**
Indications: ☐ VTE prophylaxis
- Admin Instructions:**
For Xarelto 15 mg and 20 mg, give with food or follow administration with enteral feeding to increase medication absorption. Do not administer via post-pyloric routes.
- ☒ **Pharmacy consult to monitor rivaroxaban (XARELTO) therapy** Frequency: Until discontinued Priority: STAT
- Question(s):**
Indications: VTE prophylaxis
- ☐ **warfarin (COUMADIN)**
- ☐ **WITHOUT pharmacy consult** Dose: 1 Route: oral Frequency: daily at 1700
- Question(s):**
Indication:
Dose Selection Guidance:
- ☐ **Medications**
- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** Frequency: Until discontinued Priority: Routine
- Question(s):**
Indication:
- ☐ **warfarin (COUMADIN) tablet** Dose: 1 Route: oral
- Question(s):**
Indication:
Dose Selection Guidance:
- ☒ **Mechanical Prophylaxis (Required)**
- ☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine
- Question(s):**
No mechanical VTE prophylaxis due to the following contraindication(s):
- ☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine
- Question(s):**
Side: Bilateral
Select Sleeve(s):

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

VTE Risk and Prophylaxis Tool

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

Anticoagulation Guide for COVID patients ([https://formweb.com/files/houstonmethodist/documents/COVID-19 Anticoagulation Guideline - 8.20.2021v15.pdf](https://formweb.com/files/houstonmethodist/documents/COVID-19%20Anticoagulation%20Guideline%20-%208.20.2021v15.pdf))

- ☐ Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis with Risk Stratification (Required)
- ☐ Moderate Risk - Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis (Required)

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

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

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Frequency: Once
Priority: Routine

Question(s):

No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Frequency: Once
Priority: Routine

Question(s):

No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Frequency: Once
Priority: Routine

Question(s):

No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

☒ **Patient currently has an active order for therapeutic anticoagulant or VTE prophylaxis** Frequency: Once
Priority: Routine

Question(s):

No pharmacologic VTE prophylaxis because: patient is already on therapeutic anticoagulation for other indication.
Therapy for the following:

☒ **Place sequential compression device**

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

☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

☐ **LOW Risk of VTE (Required)**

☒ **Low Risk (Required)**

☒ **Low risk of VTE** Frequency: Once Priority: Routine

Question(s):

Low risk: ☐ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation ☐ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

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

☒ **Moderate Risk (Required)**

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

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

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

☒ **Contraindications exist for pharmacologic prophylaxis** Frequency: Once Priority: Routine

Question(s):

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **Contraindications exist for pharmacologic prophylaxis** Frequency: Once Priority: Routine

Question(s):

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☒ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

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

Patient renal status: @CRCL@

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

☒ **enoxaparin (LOVENOX) injection** Dose: 30 mg Route: subcutaneous Frequency: daily at 1700

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** Route: subcutaneous Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** Dose: 2.5 mg Route: subcutaneous Frequency: daily Start Date: S+1

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

☐ **High Bleed Risk**

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

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

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

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

☐ **Not high bleed risk**

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

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

☐ **warfarin (COUMADIN)**

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

☐ **WITHOUT pharmacy consult** Dose: 1 Route: oral Frequency: daily at 1700

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Frequency: Until discontinued Priority:

Routine

Question(s):

Indication:

☐ **warfarin (COUMADIN) tablet** Dose: 1 Route: oral

Question(s):

Indication:

Dose Selection Guidance:

☒ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

☐ **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 $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

- ☐ **HEParin (porcine) injection - Q12 Hours** Dose: 5000 Units **Frequency:** every 12 hours scheduled
- ☐ **HEParin (porcine) injection - Q8 Hours** Dose: 5000 Units **Frequency:** every 8 hours scheduled
- ☐ **Not high bleed risk**
- ☐ **Wt > 100 kg** Dose: 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled
- ☐ **Wt LESS than or equal to 100 kg** Dose: 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

☐ **warfarin (COUMADIN)**

- ☐ **WITHOUT pharmacy consult** Dose: 1 **Route:** oral **Frequency:** daily at 1700

Question(s):

Indication:

Dose Selection Guidance:

- ☐ **Medications**

- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** **Frequency:** Until discontinued **Priority:**

Routine

Question(s):

Indication:

- ☐ **warfarin (COUMADIN) tablet** Dose: 1 **Route:** oral

Question(s):

Indication:

Dose Selection Guidance:

☒ **Mechanical Prophylaxis (Required)**

- ☐ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

- ☒ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

☐ **HIGH Risk of VTE - 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 $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

- ☐ **HEParin (porcine) injection - Q12 Hours** Dose: 5000 Units **Frequency:** every 12 hours scheduled
- ☐ **HEParin (porcine) injection - Q8 Hours** Dose: 5000 Units **Frequency:** every 8 hours scheduled
- ☐ **Not high bleed risk**
- ☐ **Wt > 100 kg** Dose: 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled
- ☐ **Wt LESS than or equal to 100 kg** Dose: 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

☐ **warfarin (COUMADIN)**

- ☐ **WITHOUT pharmacy consult** Dose: 1 **Route:** oral **Frequency:** daily at 1700

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** **Frequency:** Until discontinued **Priority:**

Routine

Question(s):

Indication:

- ☐ **warfarin (COUMADIN) tablet** Dose: 1 **Route:** oral

Question(s):

Indication:

Dose Selection Guidance:

☒ **Mechanical Prophylaxis (Required)**

- ☐ **Contraindications exist for mechanical prophylaxis** **Frequency:** Once **Priority:** Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

- ☒ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Priority:** Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **High Risk (Required)**

- ☒ **High risk of VTE** **Frequency:** Once **Priority:** Routine

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

- ☐ **Contraindications exist for pharmacologic prophylaxis** **Frequency:** Once **Priority:** Routine

Question(s):

No pharmacologic VTE prophylaxis due to the following contraindication(s):

- ☐ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical (Required)**

Patient renal status: @CRCL@

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

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

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

☐ **ENOXAPARIN 30 MG DAILY**

☒ **enoxaparin (LOVENOX) injection** Dose: 30 mg Route: subcutaneous Frequency: daily at 1700
Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **ENOXAPARIN SQ DAILY**

☒ **enoxaparin (LOVENOX) injection** Route: subcutaneous Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **fondaparinux (ARIXTRA) injection** Dose: 2.5 mg Route: subcutaneous Frequency: daily

Admin Instructions:

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

☐ **heparin**

High Risk Bleeding Characteristics

Age $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

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

☐ **Not high bleed risk**

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

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

☐ **warfarin (COUMADIN)**

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

☐ **WITHOUT pharmacy consult** Dose: 1 Route: oral Frequency: daily at 1700

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

☒ **Pharmacy consult to manage warfarin (COUMADIN)** Frequency: Until discontinued Priority:

Routine

Question(s):

Indication:

☐ **warfarin (COUMADIN) tablet** Dose: 1 Route: oral

Question(s):

Indication:

Dose Selection Guidance:

☒ **Mechanical Prophylaxis (Required)**

☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine

Question(s):

No mechanical VTE prophylaxis due to the following contraindication(s):

☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **High Risk (Required)**

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

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

☐ **Contraindications exist for pharmacologic prophylaxis** Frequency: Once Priority: Routine

Question(s):

No pharmacologic VTE prophylaxis due to the following contraindication(s):

☐ **aspirin chewable tablet** Dose: 162 mg Frequency: daily Start Date: S+1 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 $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

- ☐ **HEParin (porcine) injection - Q12 Hours** Dose: 5000 Units Frequency: every 12 hours scheduled
- ☐ **HEParin (porcine) injection - Q8 Hours** Dose: 5000 Units Frequency: every 8 hours scheduled
- ☐ **Not high bleed risk**
- ☐ **Wt > 100 kg** Dose: 7500 Units Route: subcutaneous Frequency: every 8 hours scheduled
- ☐ **Wt LESS than or equal to 100 kg** Dose: 5000 Units Route: subcutaneous Frequency: every 8 hours scheduled
- ☐ **Rivaroxaban and Pharmacy Consult (Required)**
- ☒ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission** Dose: 10 mg Frequency: daily at 0600 (TIME CRITICAL)
- Question(s):**
Indications: ☐ VTE prophylaxis
- Admin Instructions:**
For Xarelto 15 mg and 20 mg, give with food or follow administration with enteral feeding to increase medication absorption. Do not administer via post-pyloric routes.
- ☒ **Pharmacy consult to monitor rivaroxaban (XARELTO) therapy** Frequency: Until discontinued Priority: STAT
- Question(s):**
Indications: VTE prophylaxis
- ☐ **warfarin (COUMADIN)**
- ☐ **WITHOUT pharmacy consult** Dose: 1 Route: oral Frequency: daily at 1700
- Question(s):**
Indication:
Dose Selection Guidance:
- ☐ **Medications**
- ☒ **Pharmacy consult to manage warfarin (COUMADIN)** Frequency: Until discontinued Priority: Routine
- Question(s):**
Indication:
- ☐ **warfarin (COUMADIN) tablet** Dose: 1 Route: oral
- Question(s):**
Indication:
Dose Selection Guidance:
- ☒ **Mechanical Prophylaxis (Required)**
- ☐ **Contraindications exist for mechanical prophylaxis** Frequency: Once Priority: Routine
- Question(s):**
No mechanical VTE prophylaxis due to the following contraindication(s):
- ☒ **Place/Maintain sequential compression device continuous** Frequency: Continuous Priority: Routine
- Question(s):**
Side: Bilateral
Select Sleeve(s):

Labs**Laboratory STAT Upon Arrival**

- ☒ **Lactic acid level - ONE TIME ORDER ONLY** Frequency: STAT Frequency Limit: 1 Occurrences Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3
- Process Instructions:**
SEPSIS PATIENTS:

FOR ALL SEPSIS OR SUSPECTED SEPSIS CHANGE FREQUENCY TO: NOW THEN EVERY 3 HOURS FOR 3 OCCURRENCES

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

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

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

☒ **Urogenital ureaplasma and mycoplasma species PCR** Frequency: Once Frequency Limit: 1 Occurrences Priority: Routine Comments: Obtain with first ICU bronchoscopy

Question(s):

Specimen Source: ○ Bronchoalveolar Lavage (BAL)

Primary Ordering Comments:

This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

☒ **Ionized calcium** Frequency: STAT Frequency Limit: 1 Occurrences Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Primary Ordering Comments:

Deliver specimen immediately to the Core Laboratory.

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

Primary Ordering Comments:

Specimen must be placed on ice and delivered immediately to the Core Laboratory.

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

☒ **Phosphorus level** 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

☒ **Vitamin D 25 hydroxy level** Frequency: Once Frequency Limit: 1 Occurrences Phase of Care: Post-op Priority: STAT Specimen Type: Blood Maximum Quantity: 3

Laboratory every 6 hours x 3

☒ **Hemoglobin and hematocrit** Frequency: Every 6 hours Frequency Limit: 3 Occurrences Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3 Comments: 6 hours after Arrival

☒ **Basic metabolic panel** Frequency: Every 6 hours Frequency Limit: 3 Occurrences Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3 Comments: 6 hours after Arrival

Laboratory every 48 hours x 3

☒ **Ammonia level** Frequency: AM draw Frequency Limit: 1 Occurrences Start Date: S+2 Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3 Comments: Draw on POD 2 (Every 48 Hours)

Primary Ordering Comments:

Specimen must be placed on ice and delivered immediately to the Core Laboratory.

☒ **Ammonia level** Frequency: AM draw Frequency Limit: 1 Occurrences Start Date: S+4 Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3 Comments: Draw on POD 4 (Every 48 Hours)

Primary Ordering Comments:

Specimen must be placed on ice and delivered immediately to the Core Laboratory.

☒ **Ammonia level** Frequency: AM draw Frequency Limit: 1 Occurrences Start Date: S+6 Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3 Comments: Draw on POD 6 (Every 48 Hours)

Primary Ordering Comments:

Specimen must be placed on ice and delivered immediately to the Core Laboratory.

Troponin x 3

☒ **Troponin T** Frequency: Every 8 hours Frequency Limit: 3 Occurrences Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Laboratory Every Morning x 3 days

☒ **CBC with platelet and differential** Frequency: AM draw repeats Frequency Limit: 7 Days Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☒ **Comprehensive metabolic panel** Frequency: AM draw repeats Frequency Limit: 3 Days Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☒ **Magnesium level** Frequency: AM draw repeats Frequency Limit: 7 Days Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☒ **Phosphorus level** Frequency: AM draw repeats Frequency Limit: 7 Days Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3

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

☐ **Ionized calcium** Frequency: AM draw repeats Frequency Limit: 3 Days Phase of Care: Post-op Priority: Routine
 Specimen Type: Blood Maximum Quantity: 3
 Primary Ordering Comments:
 Deliver specimen immediately to the Core Laboratory.

☐ **LDH** Frequency: AM draw repeats Frequency Limit: 3 Days Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Immunosuppression Levels

☒ **FK506 Tacrolimus level, trough** 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
 Primary Ordering Comments:
 Nursing Instructions: Draw sample prior to administering dose. Do not delay dose administration for lab results unless specified by provider.

Post Transplant Labs Mondays x 3

☒ **Cytomegalovirus, quantitative PCR** Frequency: Every Monday Frequency Limit: 3 Occurrences Phase of Care: Post-op Priority: Routine
 Question(s):
 Specimen Source:

Arterial Blood Gas

☒ **Arterial blood gas** Frequency: STAT Frequency Limit: 1 Occurrences Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3
☒ **Arterial blood gas** Frequency: Every 6 hours Frequency Limit: 3 Occurrences Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3 Comments: Every 6 hours x 3
☒ **Arterial blood gas** Frequency: AM draw repeats Frequency Limit: 3 Days Phase of Care: Post-op Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Microbiology

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

@LASTPROCRESULT(LAB462)@

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

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

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

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

@LASTPROCRESULT(LAB462)@

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

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

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

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

☒ **Urinalysis screen and microscopy, with reflex to culture** **Frequency:** Conditional Frequency **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Urine **Comments:** One activation if temperature greater than 99.9 Fahrenheit.

Question(s):

Specimen Source: Urine

Specimen Site:

Primary Ordering Comments:

Specimen must be received in the laboratory within 2 hours of collection.

Cardiology**Cardiology**

☒ **ECG 12 lead** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** STAT **Maximum Quantity:** 6 **Comments:** STAT upon arrival to unit

Question(s):Clinical Indications: ☐ Post-Op Surgery

Interpreting Physician:

☒ **ECG 12 lead** **Frequency:** Daily **Frequency Limit:** 3 Days **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Maximum Quantity:** 6 **Comments:** Every morning times 3 days

Question(s):Clinical Indications: ☐ Post-Op Surgery

Interpreting Physician:

Imaging**X-Ray**

☒ **XR Chest 1 Vw Portable** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** STAT **Comments:** STAT upon arrival to unit.

Question(s):

Is the patient pregnant?

Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☒ **XR Chest 1 Vw Portable** **Frequency:** Daily imaging **Frequency Limit:** 7 Days **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Comments:** AM Every morning x 7 days

Question(s):

Is the patient pregnant?

Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☒ **XR Chest 1 Vw Portable** **Frequency:** Conditional Frequency **Phase of Care:** Post-op **Priority:** STAT **Comments:** Unlimited activations if temperature greater than 99.9 degrees Fahrenheit.

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****Respiratory Therapy**

☒ **Suctioning** **Frequency:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** Bag and suction with coude catheter only. Do not suction if PEEP is more than 10, unless absolutely necessary

Question(s):Route: ☐ Endotracheal

☒ **Incentive spirometry instructions** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Comments:** Start when extubated.

Question(s):Frequency of use: ☐ Every hour

☒ **Encourage deep breathing and coughing** **Frequency:** Every 2 hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** Start when extubated.

Rehab**Consults**

For Physician Consult orders use sidebar

Consults

☐ **Consult Diabetes/Endocrinology** Frequency: Once Priority: Routine

Question(s):

Provider Group:

Reason for Consult?

Patient/Clinical information communicated?

Patient/clinical information communicated?

To Provider:

Provider Group:

☒ **Consult to PT eval and treat** Frequency: Once Start Date: S+1 Phase of Care: Post-op Priority: Routine Comments:

Evaluate and treat for endurance and ambulation

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 OT eval and treat** Frequency: Once Start Date: S+1 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 Comments: Registered

Dietitian

Question(s):Reason For Consult? ☐ Other (Specify)

Specify: Post Transplant Diet Education

Purpose/Topic:

Reason for Consult?

☐ **Consult Methodist Rehab Associates** Frequency: Once Phase of Care: Post-op Priority: Routine

Question(s):Reason for Consult: ☐ PM&R Evaluation

Provider Group:

Reason for Consult?

Patient/Clinical information communicated?

Patient/clinical information communicated?

To Provider:

Provider Group:

☐ **Consult to Case Management** Frequency: Once Phase of Care: Post-op Priority: Routine

Question(s):Consult Reason: ☐ Other specify

Specify: Lung Transplant; arrange home nebulizer machine

Reason for Consult?

Process Instructions:

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

☐ **Consult to Transplant Social Work** Frequency: Once Phase of Care: Post-op Priority: Routine

Question(s):Organ Transplant: ☐ Lung

Reason for Consult?

Reason for Consult?

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

☐ **Consult to Speech Language Pathology** Frequency: Once Start Date: S+1 Phase of Care: Post-op Priority: Routine

Question(s):

Reason for consult:

Reason for SLP?

Additional Orders

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