

Location: _____

General

Common Present on Admission Diagnosis

- ☐ **Acidosis** Frequency: Once Priority: Routine
- ☐ **Acute Post-Hemorrhagic Anemia** Frequency: Once Priority: Routine
- ☐ **Acute Renal Failure** Frequency: Once Priority: Routine
- ☐ **Acute Respiratory Failure** Frequency: Once Priority: Routine
- ☐ **Acute Thromboembolism of Deep Veins of Lower Extremities** Frequency: Once Priority: Routine
- ☐ **Anemia** Frequency: Once Priority: Routine
- ☐ **Bacteremia** Frequency: Once Priority: Routine
- ☐ **Bipolar disorder, unspecified** Frequency: Once Priority: Routine
- ☐ **Cardiac Arrest** Frequency: Once Priority: Routine
- ☐ **Cardiac Dysrhythmia** Frequency: Once Priority: Routine
- ☐ **Cardiogenic Shock** Frequency: Once Priority: Routine
- ☐ **Decubitus Ulcer** Frequency: Once Priority: Routine
- ☐ **Dementia in Conditions Classified Elsewhere** Frequency: Once Priority: Routine
- ☐ **Disorder of Liver** Frequency: Once Priority: Routine
- ☐ **Electrolyte and Fluid Disorder** Frequency: Once Priority: Routine
- ☐ **Intestinal Infection due to Clostridium Difficile** Frequency: Once Priority: Routine
- ☐ **Methicillin Resistant Staphylococcus Aureus Infection** Frequency: Once Priority: Routine
- ☐ **Obstructive Chronic Bronchitis with Exacerbation** Frequency: Once Priority: Routine
- ☐ **Other Alteration of Consciousness** Frequency: Once Priority: Routine
- ☐ **Other and Unspecified Coagulation Defects** Frequency: Once Priority: Routine
- ☐ **Other Pulmonary Embolism and Infarction** Frequency: Once Priority: Routine
- ☐ **Phlebitis and Thrombophlebitis** Frequency: Once Priority: Routine
- ☐ **Protein-calorie Malnutrition** Frequency: Once Priority: Routine
- ☐ **Psychosis, unspecified psychosis type** Frequency: Once Priority: Routine
- ☐ **Schizophrenia Disorder** Frequency: Once Priority: Routine
- ☐ **Sepsis** Frequency: Once Priority: Routine
- ☐ **Septic Shock** Frequency: Once Priority: Routine
- ☐ **Septicemia** Frequency: Once Priority: Routine
- ☐ **Type II or Unspecified Type Diabetes Mellitus with Mention of Complication, Not Stated as Uncontrolled** Frequency: Once Priority: Routine
- ☐ **Urinary Tract Infection, Site Not Specified** Frequency: Once Priority: Routine

Admission or Observation (Required)

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

Question(s):

Admitting Physician:

Level of Care:

Patient Condition:

Bed request comments:

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

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

☐ **Outpatient observation services under general supervision** Frequency: Once Priority: Routine

Question(s):

Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

☐ **Outpatient in a bed - extended recovery** Frequency: Once Priority: Routine

Question(s):

Admitting Physician:
Bed request comments:

Admission or Observation

Patient has active status order on file

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

Question(s):

Admitting Physician:
Level of Care:
Patient Condition:
Bed request comments:

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

☐ **Outpatient observation services under general supervision** Frequency: Once Priority: Routine

Question(s):

Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

☐ **Outpatient in a bed - extended recovery** Frequency: Once Priority: Routine

Question(s):

Admitting Physician:
Bed request comments:

Admission

Patient has active status order on file.

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

Question(s):

Admitting Physician:
Level of Care:
Patient Condition:
Bed request comments:

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

Code Status

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

☒ **Code Status**

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

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

Question(s):

Code Status decision reached by:

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

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

Question(s):

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

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

Does patient have decision-making capacity?

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

Active until Signed by the Responsible Attending Physician.:

Code Status decision reached by:

☐ **Consult to Palliative Care Service**

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

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

Question(s):

Priority:

Reason for Consult?

Order?

Name of referring provider:

Enter call back number:

Reason for Consult?

Process Instructions:

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

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

Question(s):

Reason for Consult:

Reason for Consult?

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

Question(s):

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

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

Does patient have decision-making capacity?

Modified Code restrictions:

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

Code Status decision reached by:

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

Treatment Restrictions Priority: Routine

Question(s):

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

Treatment Restriction decision reached by:

Specify Treatment Restrictions:

Code Status decision reached by:

Process Instructions:

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

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

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

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

Isolation

☐ **Airborne isolation status**

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

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

Frequency: Once Priority: Routine

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

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

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

Precautions

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

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

Question(s):

Increased observation level needed:

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

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

Question(s):

Increased observation level needed:

Nursing

Vital Signs

- ☒ **Vital signs - T/P/R/BP (per unit protocol)** Frequency: Per unit protocol Priority: Routine
- ☒ **Pulse oximetry continuous** Frequency: Continuous Priority: Routine

Question(s):

Current FIO2 or Room Air:

Activity

- ☒ **Activity (specify)** Frequency: 2 times daily Priority: Routine

Question(s):

Specify: ☐ Up with assistance ☐ Up in chair

- ☐ **Ambulate with assistance** Frequency: 3 times daily Priority: Routine

Question(s):

Specify: ☐ with assistance

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

Nursing Care

- ☐ **Daily weights** Frequency: Daily Priority: Routine
- ☒ **Strict intake and output** Frequency: Every hour Priority: Routine
- ☐ **Measure central venous pressure** Frequency: Every 4 hours Priority: Routine
- ☐ **Hemodynamic Monitoring** Frequency: Continuous Priority: Routine

Question(s):

Measure:

- ☐ **Insert and Maintain Temperature Sensing Foley**

- ☒ **Insert Foley catheter** Frequency: Once Priority: Routine

Question(s):

Type: ☐ Temperature Sensing

Size:

Urinometer needed:

Indication:

Primary Ordering Comments:

Foley catheter may be removed per nursing protocol.

- ☒ **Foley Catheter Care** Frequency: Until discontinued Priority: Routine

Question(s):

Orders: Maintain

- ☐ **Nasogastric tube insert and maintain**

- ☒ **Nasogastric tube insertion** Frequency: Once Priority: Routine

Question(s):

Type:

- ☐ **Nasogastric tube maintenance** Frequency: Until discontinued Priority: Routine

Question(s):

Tube Care Orders:

- ☐ **Neurological assessment** Frequency: Every shift Priority: Routine

Question(s):

Assessment to Perform:

- ☒ **Oral care for intubated patients** Frequency: Every 4 hours Priority: Routine Comments: For intubated patients
- ☒ **Oral care for non intubated patients** Frequency: Every shift Priority: Routine Comments: For non intubated patients

- ☐ **Peripheral vascular assessment** Frequency: Every 6 hours Priority: Routine

- ☒ **Elevate HOB** Frequency: Until discontinued Priority: Routine

Question(s):

Head of bed: ☐ 30 degrees

Notify

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

☐ **Notify Physician for vitals:** Frequency: Until discontinued Priority: Routine

Question(s):

Temperature greater than: 100.5

Temperature less than:

Systolic BP greater than: 160

Systolic BP less than: 90

Diastolic BP greater than: 100

Diastolic BP less than: 50

MAP less than: 60.000

Heart rate greater than (BPM): 100

Heart rate less than (BPM): 60

Respiratory rate greater than: 25

Respiratory rate less than: 8

SpO2 less than: 92

☐ **Notify Physician for acute changes in neurological status** Frequency: Until discontinued Priority: Routine

☐ **Notify Physician for no bowel movement in 72 hours** Frequency: Until discontinued Priority: Routine

Diet

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

Question(s):

NPO:

Pre-Operative fasting options:

Process Instructions:

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

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

Question(s):

NPO: ☐ Except meds

Pre-Operative fasting options:

Process Instructions:

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

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

Question(s):

Diet(s):

Cultural/Special:

Cultural/Special:

Other Options:

Other Options:

Advance Diet as Tolerated?

IDDSI Liquid Consistency:

Fluid Restriction:

Foods to Avoid:

Foods to Avoid:

☐ **Feeding tube**

☒ **Tube feeding - continuous** Frequency: Continuous Priority: Routine

Question(s):

Tube Feeding Schedule: ☐ Continuous

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Schedule:

Dietitian to manage Tube Feed?

☒ **XR Abdomen 1 Vw** Frequency: 1 time imaging Priority: Routine

Question(s):

Is the patient pregnant?

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

IV Fluids

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

Bolus Fluids

IV Fluids for COVID-19 Should be Minimized

- ☐ **sodium chloride 0.9 % bolus 500 mL** Dose: 500 mL Route: intravenous Frequency: once Frequency Limit: 1 Occurrences Minimum Infusion Duration: 15.000 Minutes
- ☐ **sodium chloride 0.9 % bolus 1000 mL** Dose: 1000 mL Route: intravenous Frequency: once Frequency Limit: 1 Occurrences Minimum Infusion Duration: 30.000 Minutes
- ☐ **lactated ringer's bolus 500 mL** Dose: 500 mL Route: intravenous Frequency: once Frequency Limit: 1 Occurrences Minimum Infusion Duration: 15.000 Minutes
- ☐ **lactated ringers bolus 1000 mL** Dose: 1000 mL Route: intravenous Frequency: once Frequency Limit: 1 Occurrences Minimum Infusion Duration: 30.000 Minutes
- ☐ **albumin human 5 % bottle** Dose: 25 g Route: intravenous Frequency: once Frequency Limit: 1 Occurrences Minimum Infusion Duration: 15.000 Minutes
- Question(s):
Indication:

Maintenance IV Fluids

- ☐ **sodium chloride 0.9 % infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous
- ☐ **dextrose 5%-0.9% sodium chloride infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous
- ☐ **dextrose 5 % and lactated Ringer's infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous
- ☐ **lactated Ringer's infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous
- ☐ **sodium chloride 0.45 % 1,000 mL with sodium bicarbonate 75 mEq/L infusion** Dose: 75 mL/hr Route: intravenous Frequency: continuous

Medications

Antibiotics

- ☐ **IV Vancomycin Loading Dose + Pharmacy Consult**
- ☒ **vancomycin (VANCOCIN) IV** Route: intravenous Frequency: once Frequency Limit: 1 Occurrences Priority: STAT
- Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
Loading Dose
- ☒ **Pharmacy consult to manage vancomycin** Frequency: Until discontinued Priority: Routine
- Question(s):
Indication:
Anticipated Duration of Vancomycin Therapy (Days):
Process Instructions:
All eligible patients to receive Vancomycin at AUC 400-600 and Trough 10-20.
- ☐ **piperacillin-tazobactam (ZOSYN) IV** Route: intravenous Frequency: every 8 hours Priority: STAT
- Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
EXTENDED INFUSION Administer over 4 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.
- ☐ **cefepime (MAXIPIME) IV** Route: intravenous Frequency: every 8 hours Priority: STAT
- Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:
Admin Instructions:
EXTENDED INFUSION Administer over 3 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.
- ☐ **cefTRIAxone (ROCEPHIN) IV** Route: intravenous Priority: STAT
- Question(s):
Indication:
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

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

☐ **azithromycin (ZITHROMAX) IV Route:** intravenous **Priority:** STAT

Question(s):

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

Indication:

Product Admin Instructions:

May cause QTc prolongation.

☐ **metronidazole (FLAGYL) IV Route:** intravenous **Priority:** STAT

Question(s):

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

Indication:

☐ **meropenem (MERREM) IV Route:** intravenous **Frequency:** every 8 hours **Priority:** STAT

Question(s):

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

Indication:

Admin Instructions:

****EXTENDED INFUSION**** Administer over 3 hours via a dedicated line when possible. Following completion of infusion, flush line with 20 mL of NS or hang as a secondary with flush provided by the maintenance fluid.

Scheduled Antihypertensives

☐ **labetalol (NORMODYNE) tablet Dose:** 100 **Route:** oral **Frequency:** 2 times daily

Question(s):

BP & HR HOLD parameters for this order: ☐ BP & HR HOLD Parameters requested

BP & HR HOLD for: ☐ Heart Rate LESS than 60 bpm ☐ Systolic BP LESS than 100 mmHg

Contact Physician if:

☐ **labetalol (NORMODYNE) Route:** intravenous **Frequency:** 2 times daily

Question(s):

BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested

BP & HR HOLD for: Other Systolic BP

Hold for Systolic BP LESS than (in mmHg): 110

Admin Instructions:

Administer if Systolic BP GREATER than ***

☐ **metoprolol tartrate (LOPRESSOR) tablet Dose:** 100 **Route:** oral **Frequency:** 2 times daily

Question(s):

BP & HR HOLD parameters for this order: ☐ BP & HR HOLD Parameters requested

BP & HR HOLD for: ☐ Heart Rate LESS than 60 bpm ☐ Systolic BP LESS than 100 mmHg

Contact Physician if:

☐ **metoprolol (LOPRESSOR) injection Dose:** 5 **Route:** intravenous

Question(s):

BP & HR HOLD parameters for this order: ☐ BP & HR HOLD Parameters requested

BP & HR HOLD for: ☐ Heart Rate LESS than 60 bpm ☐ Systolic BP LESS than 100 mmHg

Contact Physician if:

Admin Instructions:

Maximum total dose is 15 mg over a 10-15 minute period.

☐ **hydrALAZINE (APRESOLINE) injection Dose:** 20 **Route:** intravenous **Frequency:** every 6 hours **PRN Reasons:** high blood pressure

Question(s):

BP HOLD parameters for this order:

Contact Physician if:

Admin Instructions:

Administer if Systolic BP GREATER than ***

PRN Antihypertensives

☐ **labetalol (NORMODYNE, TRANDATE) injection - Select an alternative agent if heart rate is LESS than 55 BPM Dose:**

10 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Comment:** Systolic Blood Pressure GREATER than 160 mmHg

PRN Reasons: high blood pressure

Question(s):

BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested

BP & HR HOLD for: Other Heart Rate

Hold for Heart Rate LESS than (in bpm): 55

Admin Instructions:

Administer at 2 mg/minute.

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

☐ **hydrALAZINE (APRESOLINE) injection - Use alternative therapy if patient is tachycardic (GREATER than 100 BPM)**

Dose: 10 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Comment:** Systolic Blood Pressure GREATER than 160 mmHg **PRN Reasons:** high blood pressure

Question(s):

Hold for Heart Rate GREATER than (in bpm): 100

BP HOLD parameters for this order:

Contact Physician if:

Admin Instructions:

Administer if Systolic BP GREATER than ***

Vasoactive Infusions

☐ **niCARDipine (CARDENE) IV infusion** **Frequency:** titrated

☐ **norEPIneprine (LEVOPHED) infusion** **Frequency:** titrated **Priority:** STAT

☐ **epINEPPrine infusion** **Frequency:** titrated **Priority:** STAT

Active GI Bleeding

☐ **pantoprazole (PROTONIX) injection - bolus** **Dose:** 80 mg **Route:** intravenous **Frequency:** once PRN **PRN Comment:** for GI Bleed

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:

☐ **pantoprazole (PROTONIX) IV** **Dose:** 8 mg/hr **Route:** intravenous **Minimum Infusion Duration:** 10.000 Hours

Question(s):

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

☐ **octreotide (SANDOSTATIN) injection - bolus** **Dose:** 100 mcg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences

☐ **octreotide (SandoSTATIN) IV** **Dose:** 50 mcg/hr **Route:** intravenous **Frequency:** continuous **Minimum Infusion Duration:** 10.000 Hours

Stress Ulcer Prophylaxis

☐ **famotidine (PEPCID) IV or ORAL**

☒ **famotidine (PEPCID) injection** **Dose:** 20 mg **Route:** intravenous **Frequency:** 2 times daily **Minimum Volume:** 2.000 mL

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:

Admin Instructions:

IV or ORAL

☒ **famotidine (PEPCID) tablet** **Dose:** 20 mg **Route:** oral **Frequency:** 2 times daily

Question(s):

Indication(s) for H2 Receptor Antagonist (H2RA) Therapy:

Admin Instructions:

IV or ORAL

☐ **pantoprazole (PROTONIX) IV or Oral or Tube**

☒ **pantoprazole (PROTONIX) EC tablet** **Dose:** 40 mg **Route:** oral **Frequency:** daily at 0600

Question(s):

Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

Admin Instructions:

Give if patient is able to swallow

☒ **pantoprazole (PROTONIX) 40 mg in sodium chloride 0.9 % 10 mL injection** **Dose:** 40 mg **Route:** intravenous

Frequency: daily at 0600

Question(s):

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

Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

Admin Instructions:

Give if patient is unable to tolerate oral medication

☒ **pantoprazole (PROTONIX) suspension** **Dose:** 40 mg **Route:** feeding tube **Frequency:** daily at 0600

Question(s):

Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

Admin Instructions:

Give if patient is unable to swallow

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

☐ **omeprazole (PriLOSEC) suspension** Dose: 40 mg Route: Nasogastric Frequency: once Frequency Limit: 1 Occurrences

Question(s):

Indication(s) for Proton Pump Inhibitor (PPI) Therapy:

Admin Instructions:

Separate administration with all other oral medications by 1 hour.

Constipation

- ☐ **bisacodyl (DULCOLAX) EC tablet** Dose: 10 mg Route: oral Frequency: daily PRN PRN Reasons: constipation
- ☐ **bisacodyl (DULCOLAX) suppository** Dose: 10 mg Route: rectal Frequency: daily PRN PRN Reasons: constipation
- ☐ **lactulose solution** Dose: 20 g Route: oral Frequency: every 8 hours PRN PRN Reasons: constipation
- ☐ **polyethylene glycol (GLYCOLAX) packet** Dose: 17 g Route: oral Frequency: daily PRN PRN Reasons: constipation

Product Admin Instructions:

Mix in 4-8oz of water.

☐ **docusate (COLACE) 50 mg/5 mL liquid** Dose: 50 Route: Nasogastric Frequency: 2 times daily PRN PRN Reasons: constipation

☐ **docusate sodium (COLACE) capsule** Dose: 100 mg Route: oral Frequency: 2 times daily

Antiemetics

☐ **ondansetron (ZOFTRAN) IV** Dose: 4 mg Route: intravenous Frequency: every 8 hours PRN PRN Reasons: nausea vomiting

Product Admin Instructions:

May cause QTc prolongation.

☐ **promethazine (PHENERGAN) IVPB or Oral or Rectal**

☒ **promethazine (PHENERGAN) 25 mg in sodium chloride 0.9 % 50 mL IVPB** Dose: 12.5 mg Route: intravenous Frequency: every 6 hours PRN Minimum Infusion Duration: 30.000 Minutes PRN Reasons: nausea vomiting

Admin Instructions:

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

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

Admin Instructions:

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

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

Admin Instructions:

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

Antiemetics

☐ **ondansetron (ZOFTRAN) IV** Dose: 4 mg Route: intravenous Frequency: every 8 hours PRN PRN Reasons: nausea vomiting

Product Admin Instructions:

May cause QTc prolongation.

☐ **promethazine (PHENERGAN) IV or Oral or Rectal**

☒ **promethazine (PHENERGAN) injection** Dose: 12.5 mg Route: intravenous Frequency: every 6 hours PRN PRN Reasons: nausea vomiting

Admin Instructions:

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

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

Admin Instructions:

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

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

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

Reasons: nausea

vomiting

Admin Instructions:

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

Antiemetics

☐ **ondansetron (ZOFTRAN) IV** Dose: 4 mg Route: intravenous Frequency: every 8 hours PRN PRN Reasons: nausea vomiting

Product Admin Instructions:

May cause QTc prolongation.

☐ **promethazine (PHENERGAN)**

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

Reasons: nausea

vomiting

Admin Instructions:

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

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

nausea

vomiting

Admin Instructions:

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

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

Reasons: nausea

vomiting

Admin Instructions:

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

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

hours PRN PRN Reasons: nausea

vomiting

Admin Instructions:

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

☐ **PRN Mild Pain (Pain Score 1-3) or Fever**

(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).

☒ **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 Medications 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)

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

☒ **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.

☐ **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) 10-325 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.

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

☒ **HYDROcodone-acetaminophen (HYCET) 7.5-325 mg/15 mL solution** Dose: 20 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 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 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 Medications for Moderate Pain (Pain Score 4-6): For Patients GREATER 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.

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

(adjust dose for renal/liver function and age)

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

Admin Instructions:

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

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

(adjust dose for renal/liver function and age)

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

Admin Instructions:

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

☐ **PRN Oral Medications 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 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 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.

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

☐ **oxyCODONE (ROXICODONE) immediate release tablet** Dose: 10 mg Route: oral Frequency: every 6 hours PRN 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 Medications 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 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 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 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 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 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 Medications for Severe Pain (Pain Score 7-10): For Patients LESS than 65 years old**
(adjust dose for renal/liver function and age)

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

Admin Instructions:

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

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

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

Admin Instructions:

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

☐ **PRN IV Medications for Severe Pain (Pain Score 7-10): For Patients GREATER than 65 years old**
(adjust dose for renal/liver function and age)

☐ **fentanyl (SUBLIMAZE) injection** Dose: 25 mcg Route: intravenous Frequency: every 3 hours PRN 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 PRN Reasons: severe pain (score 7-10)

Admin Instructions:

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

☐ **HYDROMORPHONE (DILAUDID) injection** Dose: 0.5 mg Route: intravenous Frequency: every 3 hours PRN PRN Reasons: severe pain (score 7-10)

Admin Instructions:

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

Nebulized Medications

☐ **albuterol (PROVENTIL) nebulizer solution** Dose: 2.5 mg Route: nebulization Frequency: Respiratory Therapy - every 6 hours

Question(s):

Aerosol Delivery Device:

☐ **albuterol (PROVENTIL) nebulizer solution** Dose: 2.5 mg Route: nebulization Frequency: every 4 hours PRN PRN Reasons: 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

Question(s):

Aerosol Delivery Device:

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

Question(s):

Aerosol Delivery Device:

Eye Care

☐ **artificial tears ointment** Route: Both Eyes Frequency: every 4 hours PRN PRN Reasons: dry eyes

Admin Instructions:

Required for patients on paralytic agents or seventh cranial nerve palsy (Bell's Palsy)

☐ **hypromellose (NATURES TEARS) ophthalmic solution** Dose: 2 drop Route: Both Eyes Frequency: every 2 hour PRN PRN Reasons: dry eyes

Admin Instructions:

Required for patients on paralytic agents or seventh cranial nerve palsy (Bell's Palsy)

Product Admin Instructions:

For Ophthalmic use only

Insomnia

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

Pharmacy Consults

☐ **Pharmacy consult to change IV medications to concentrate fluids maximally** Frequency: Until discontinued Priority: Routine

☐ **Pharmacy consult to manage dose adjustments for renal function** Frequency: Until discontinued Priority: Routine

Question(s):

Adjust dose for:

Primary Ordering Comments:

Please assess for hemodialysis, peritoneal dialysis, or continuous renal replacement therapy (CRRT) orders in addition to creatine clearance when making dose adjustments.

☐ **Pharmacy consult to manage Heparin: LOW Dose protocol(ACS/Stroke/Afib)- withOUT titration boluses** Frequency:

Until discontinued **Priority:** STAT

Question(s):

Monitoring: Anti-Xa

Heparin Indication:

Specify:

Process Instructions:

Low Dose Heparin Protocol

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

See protocol for details

☐ **Pharmacy Consult to Manage Heparin: STANDARD dose protocol (DVT/PE) - with titration boluses** Frequency: Until discontinued **Priority:** STAT

Question(s):

Heparin Indication:

Specify:

Specify:

Monitoring:

Process Instructions:

Standard Dose Protocol

- IF ORDERED, Initial Bolus (80 units/kg) with no maximum.
- Consider in patients at risk for recurrent embolization.
- Initial Infusion (18 units/kg/hr) with no maximum.
- More aggressive titration with additional bolus and increase in heparin for sub-therapeutic monitoring levels.

See protocol for details

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

Question(s):

Indication:

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)

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

Sign: _____ Printed Name: _____ Date/Time: _____
Page 17 of 58

☒ **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**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

☐ **LOW Risk of VTE (Required)**

☒ **Low Risk (Required)**

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

Question(s):

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

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

☒ **Moderate Risk (Required)**

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

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

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

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

Question(s):

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ **ENOXAPARIN SQ DAILY**

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ **heparin**

High Risk Bleeding Characteristics

Age $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

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

☐ **Not high bleed risk**

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

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

☐ **warfarin (COUMADIN)**

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

Question(s):

Indication:

Dose Selection Guidance:

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

☐ Medications

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

Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ Mechanical Prophylaxis (Required)

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

☒ **Moderate Risk** (Required)

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

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

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

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

Question(s):

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

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

Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

Question(s):

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ **ENOXAPARIN SQ DAILY**

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ **heparin**

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

☐ **High Bleed Risk**

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

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

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

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

☐ **Not high bleed risk**

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

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

☐ **warfarin (COUMADIN)**

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

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

Priority: Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **High Risk (Required)**

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

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ **ENOXAPARIN SQ DAILY**

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ **heparin**

High Risk Bleeding Characteristics

Age $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

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

☐ **warfarin (COUMADIN)**

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

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

Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

- ☒ **High Risk (Required)**

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

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

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

☐ ENOXAPARIN 30 MG DAILY

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ ENOXAPARIN SQ DAILY

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ heparin

High Risk Bleeding Characteristics

Age $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ High Bleed Risk

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

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

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

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

☐ Not high bleed risk

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

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

☐ warfarin (COUMADIN)

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

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

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

Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **High Risk (Required)**

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

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

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

Question(s):

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

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

☐ **aspirin (ECOTRIN) enteric coated tablet** Dose: 162 mg Frequency: daily Start Date: S+1

☐ **Apixaban and Pharmacy Consult (Required)**

☒ **apixaban (ELIQUIS) tablet** Dose: 2.5 mg Frequency: 2 times daily Start Date: S+1

Question(s):

Indications: ☐ VTE prophylaxis

☒ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy** Frequency: Until discontinued Priority:

STAT

Question(s):

Indications: VTE prophylaxis

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

Patient renal status: @CRCL@

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

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ **ENOXAPARIN SQ DAILY**

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ **heparin**

High Risk Bleeding Characteristics

Age $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

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

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

VTE Risk and Prophylaxis Tool

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

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

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

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

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

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

Question(s):

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

☒ **Place sequential compression device**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

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

Question(s):

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

☒ **Place sequential compression device**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

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

Question(s):

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

☒ **Place sequential compression device**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

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

Question(s):

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

☒ **Place sequential compression device**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

☐ **LOW Risk of VTE (Required)**

☒ **Low Risk (Required)**

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

Question(s):

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

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

☒ **Moderate Risk (Required)**

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

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

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

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

Question(s):

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ **ENOXAPARIN SQ DAILY**

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ **heparin**

High Risk Bleeding Characteristics

Age $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

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

☐ **Not high bleed risk**

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

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

☐ **warfarin (COUMADIN)**

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

Question(s):

Indication:

Dose Selection Guidance:

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

☐ **Medications**

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

Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **Moderate Risk (Required)**

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

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

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

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

Question(s):

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

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

☐ ENOXAPARIN 30 MG DAILY

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ ENOXAPARIN SQ DAILY

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ heparin

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

☐ High Bleed Risk

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

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

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

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

☐ Not high bleed risk

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

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

☐ warfarin (COUMADIN)

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

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

Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis** (Required)

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

Address both pharmacologic and mechanical prophylaxis by ordering from Pharmacological and Mechanical Prophylaxis.

☒ **High Risk** (Required)

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

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ **ENOXAPARIN SQ DAILY**

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ **heparin**

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

☐ **High Bleed Risk**

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

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

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

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

☐ **Not high bleed risk**

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

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

☐ **warfarin (COUMADIN)**

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

Question(s):

Indication:

Dose Selection Guidance:

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

☐ Medications

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

Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ High Risk of VTE - Non-Surgical (Required)

Address both pharmacologic and mechanical prophylaxis by ordering from Pharmacological and Mechanical Prophylaxis.

☒ High Risk (Required)

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

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

☐ ENOXAPARIN 30 MG DAILY

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ ENOXAPARIN SQ DAILY

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

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

☐ heparin

High Risk Bleeding Characteristics

Age $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

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

☐ **Not high bleed risk**

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

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

☐ **warfarin (COUMADIN)**

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

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

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

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

Address both pharmacologic and mechanical prophylaxis by ordering from Pharmacological and Mechanical Prophylaxis.

☒ **High Risk** (Required)

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

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

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

Question(s):

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

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

- ☐ **aspirin chewable tablet** Dose: 162 mg Frequency: daily Start Date: S+1
- ☐ **aspirin (ECOTRIN) enteric coated tablet** Dose: 162 mg Frequency: daily Start Date: S+1
- ☐ **Apixaban and Pharmacy Consult (Required)**
- ☒ **apixaban (ELIQUIS) tablet** Dose: 2.5 mg Frequency: 2 times daily Start Date: S+1
- Question(s):**
Indications: ○ VTE prophylaxis
- ☒ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy** Frequency: Until discontinued Priority: STAT
- Question(s):**
Indications: VTE prophylaxis
- ☐ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation (Required)**
- Patient renal status: @CRCL@**

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

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

- ☐ **ENOXAPARIN 30 MG DAILY**
- ☒ **enoxaparin (LOVENOX) injection** Dose: 30 mg Route: subcutaneous Frequency: daily at 1700
- Start Date:** S+1
- Question(s):**
Indication(s):
- Product Admin Instructions:**
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.
- ☐ **ENOXAPARIN SQ DAILY**
- ☒ **enoxaparin (LOVENOX) injection** Route: subcutaneous Start Date: S+1
- Question(s):**
Indication(s):
- Product Admin Instructions:**
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.
- ☐ **fondaparinux (ARIXTRA) injection** Dose: 2.5 mg Route: subcutaneous Frequency: daily Start Date: S+1
- Admin Instructions:**
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min
- ☐ **heparin**

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

High Risk Bleeding 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

☐ **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:

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)
- ☒ 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**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

☐ **LOW Risk of VTE (Required)**

☒ **Low Risk (Required)**

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

Question(s):

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

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

☒ **Moderate Risk (Required)**

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

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

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

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

Question(s):

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ **ENOXAPARIN SQ DAILY**

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ **heparin**

High Risk Bleeding Characteristics

Age $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

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

☐ **warfarin (COUMADIN)**

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

Question(s):

Indication:

Dose Selection Guidance:

- ☐ **Medications**

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

Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

- ☒ **Moderate Risk (Required)**

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

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

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

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

Question(s):

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

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

Routine

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

Question(s):

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

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

Question(s):

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

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

☐ Enoxaparin for Prophylactic Anticoagulation Nonsurgical (Required)

Patient renal status: @CRCL@

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

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

☐ ENOXAPARIN 30 MG DAILY

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

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ ENOXAPARIN SQ DAILY

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ heparin

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

☐ High Bleed Risk

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

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

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

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

☐ **Not high bleed risk**

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

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

☐ **warfarin (COUMADIN)**

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

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

Priority: Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **High Risk (Required)**

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

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

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

☐ ENOXAPARIN 30 MG DAILY

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ ENOXAPARIN SQ DAILY

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ heparin

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

☐ High Bleed Risk

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

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

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

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

☐ **warfarin (COUMADIN)**

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

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

Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

- ☒ **High Risk (Required)**

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

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

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

☐ ENOXAPARIN 30 MG DAILY

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ ENOXAPARIN SQ DAILY

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ heparin

High Risk Bleeding Characteristics

Age $\geq$ 75

Weight < 50 kg

Unstable Hgb

Renal impairment

Plt count < 100 K/uL

Dual antiplatelet therapy

Active cancer

Cirrhosis/hepatic failure

Prior intra-cranial hemorrhage

Prior ischemic stroke

History of bleeding event requiring admission and/or transfusion

Chronic use of NSAIDs/steroids

Active GI ulcer

☐ **High Bleed Risk**

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

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

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

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

☐ **Not high bleed risk**

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

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

☐ **warfarin (COUMADIN)**

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Medications**

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

Routine

Question(s):

Indication:

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

Question(s):

Indication:

Dose Selection Guidance:

☐ **Mechanical Prophylaxis (Required)**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

☒ **High Risk (Required)**

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

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

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

Question(s):

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

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

☐ **aspirin (ECOTRIN) enteric coated tablet** Dose: 162 mg Frequency: daily Start Date: S+1

☐ **Apixaban and Pharmacy Consult (Required)**

☒ **apixaban (ELIQUIS) tablet** Dose: 2.5 mg Frequency: 2 times daily Start Date: S+1

Question(s):

Indications: ☐ VTE prophylaxis

☒ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy** Frequency: Until discontinued Priority:

STAT

Question(s):

Indications: VTE prophylaxis

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

Patient renal status: @CRCL@

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

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ **ENOXAPARIN SQ DAILY**

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

Admin Instructions:

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

☐ **heparin**

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

☐ **High Bleed Risk**

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

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

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

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

Labs

Hematology/Coagulation

- ☐ **CBC with differential** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3
- ☐ **CBC hemogram** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3
- Primary Ordering Comments:**
CBC only; Does not include a differential
- ☐ **D-dimer** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3
- ☐ **Fibrinogen** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3
- ☐ **Hemoglobin and hematocrit** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3
- ☐ **Prothrombin time with INR** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

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

☐ **Partial thromboplastin time** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Primary Ordering Comments:

Do not draw blood from the arm that has heparin infusion. Do not draw from heparin flushed lines. If there is no other access other than the heparin line, then stop the heparin, flush the line, and aspirate 20 ml of blood to waste prior to drawing a specimen.

Chemistry

☐ **Amylase** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Basic metabolic panel** Frequency: Once Frequency Limit: 1 Occurrences Ordering Quantity: 1 Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Blood gas, arterial** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Blood gas, venous** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Calcium** Frequency: Once Frequency Limit: 1 Occurrences Ordering Quantity: 1 Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Calcium, ionized** Frequency: Once Frequency Limit: 1 Occurrences Ordering Quantity: 1 Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Primary Ordering Comments:

Deliver specimen immediately to the Core Laboratory.

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

☐ **Hepatic function panel** Frequency: Once Frequency Limit: 1 Occurrences Ordering Quantity: 1 Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Lactic acid level - ONE TIME ORDER ONLY** Frequency: Now then every 4 hours Frequency Limit: 2 Occurrences 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

☐ **Lipase** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Magnesium** Frequency: Once Frequency Limit: 1 Occurrences Ordering Quantity: 1 Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Phosphorus** Frequency: Once Frequency Limit: 1 Occurrences Ordering Quantity: 1 Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Osmolality, serum** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Cardiac

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

☐ **Troponin T : Now and every 6 hours x 2** Frequency: Now then every 6 hours Frequency Limit: 2 Occurrences Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Troponin T : Now and every 8 hours x 2** Frequency: Now then every 8 hours Frequency Limit: 2 Occurrences Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Urine

☐ **Urinalysis screen and microscopy, with reflex to culture** Frequency: Once Priority: Routine Specimen Type: Urine Question(s):

Specimen Source: Urine

Specimen Site:

Primary Ordering Comments:

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

☐ **Urine drugs of abuse screen** Frequency: Once Priority: Routine Specimen Type: Urine

☐ **Sodium level, urine, random** Frequency: Once Priority: Routine Specimen Type: Urine

☐ **Creatinine level, urine, random** Frequency: Once Priority: Routine Specimen Type: Urine

☐ **Potassium, urine, random** Frequency: Once Priority: Routine Specimen Type: Urine

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

Microbiology

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

☐ **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.

☐ **Respiratory pathogen panel with COVID-19** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nasopharyngeal

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

Cardiology

Cardiology

☐ **ECG 12 lead-STAT** **Frequency:** Once **Priority:** STAT **Maximum Quantity:** 6

Question(s):

Clinical Indications:

Interpreting Physician:

☐ **ECG 12 lead** **Frequency:** Every 8 hours **Frequency Limit:** 3 Occurrences **Priority:** Routine **Maximum Quantity:** 6

Question(s):

Clinical Indications:

Interpreting Physician:

☐ **Echocardiogram 2d complete with contrast** **Frequency:** 1 time imaging **Priority:** Routine

Question(s):

Does this study require a chemo toxicity strain protocol?

Does this exam need a strain protocol?

Call back number for Critical Findings:

Where should test be performed?

Does this exam need a bubble study?

Preferred interpreting Cardiologist or group:

Process Instructions:

If this patient has had an echocardiogram ordered/performed within the past 120 hours as indicated by repeat Echo orders report on the left. Please contact the Echo department at 713-441-2222 to discuss the reason for a repeat exam with a cardiologist.

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

Other Indications should be ordered for TODAY or Routine.

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

Imaging

CT

☐ **CT Head W/ Contrast** **Frequency:** 1 time imaging **Priority:** Routine

Question(s):

Does this require fiducials?

Is the patient pregnant?

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

X-Ray

☐ **Chest 1 Vw Portable** **Frequency:** 1 time imaging **Priority:** Routine

Question(s):

Is the patient pregnant?

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

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

☐ **XR Abdomen 1 Vw** Frequency: 1 time imaging Priority: Routine Comments: Portable

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

☐ **Mechanical ventilation** Frequency: Continuous Priority: Routine

Question(s):

Mechanical Ventilation:

Vent Management Strategies: Adult Respiratory Ventilator Protocol

☐ **Oxygen therapy** Frequency: Continuous Priority: Routine

Question(s):

Initial Device:

Device:

SpO2 Goal:

SpO2 Goal:

Titrate FiO2 to keep O2 saturations:

Notify Physician if:

Indications for O2 therapy:

Indications for O2 therapy:

Primary Ordering Comments:

@CERMSG(661071:25704)@

Rehab

Consults

Ancillary Consults

☐ **Consult to Case Management** Frequency: Once Priority: Routine

Question(s):

Consult Reason:

Reason for Consult?

Process Instructions:

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

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

Question(s):

Reason for Consult:

Reason for Consult?

☒ **Consult PT eval and treat** Frequency: Once Priority: Routine

Question(s):

Reasons for referral to Physical Therapy (mark all applicable):

Are there any restrictions for positioning or mobility?

Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):

Weight Bearing Status:

Reason for PT?

Process Instructions:

If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting physical therapy

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

☐ **Consult to Nutrition Services - if patient NPO for greater than 24 hours** Frequency: Once Priority: Routine Comments: if patient NPO for greater than 24 hours

Question(s):

Reason For Consult?

Purpose/Topic:

Reason for Consult?

☐ **Consult to Spiritual Care** Frequency: Once Priority: Routine

Question(s):

Reason for consult?

Reason for Consult?

Process Instructions:

For requests after hours, call the house operator.

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

☐ **Consult to Speech Language Pathology** Frequency: Once Priority: Routine

Question(s):

Reason for consult:

Reason for SLP?

☐ **Consult to PT Wound Care Eval and Treat** Frequency: Once Priority: Routine

Question(s):

Special Instructions:

Location of Wound?

Reason for PT?

☐ **Consult to Palliative Care Service**

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

Question(s):

Priority:

Reason for Consult?

Order?

Name of referring provider:

Enter call back number:

Reason for Consult?

Process Instructions:

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

Additional Orders