

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:

- ☐ **Spinal precautions** Frequency: Continuous Priority: Routine

Nursing**Vital Signs**

- ☒ **Vital signs - T/P/R/BP** Frequency: Every hour Priority: Routine Comments: Aligned with neurological assessments.
- ☒ **Pulse oximetry check** Frequency: Continuous Priority: Routine

Question(s):

Current FIO2 or Room Air:

Vital Signs

- ☒ **Vital signs - T/P/R/BP** Frequency: Every 15 min Priority: Routine Comments: Every 15 minutes x 2 hours then every 1 hour. For Temp, check every 4 hours.
- ☒ **Pulse oximetry check** Frequency: Continuous Priority: Routine

Question(s):

Current FIO2 or Room Air:

Activity

- ☐ **Strict bed rest** Frequency: Until discontinued Priority: Routine
- ☐ **Turn patient** Frequency: Every 2 hours Priority: Routine
- ☐ **Up with assistance** Frequency: Until discontinued Priority: Routine

Question(s):Specify: ☐ Up with assistance

- ☐ **Activity as tolerated** Frequency: Until discontinued Priority: Routine

Question(s):Specify: ☐ Activity as tolerated

- ☐ **Elevate Head of bed 30 degrees or greater (semi-recumbent)** Frequency: Until discontinued Priority: Routine
- Comments: or greater (semi-recumbent)

Question(s):Head of bed: ☐ 30 degrees

- ☐ **Head of bed flat** Frequency: Until discontinued Priority: Routine

Question(s):Head of bed: ☐ flat**Nursing**

- ☒ **Neurological assessment** Frequency: Every hour Priority: Routine

Question(s):Assessment to Perform: ☐ Level of Consciousness ☐ Motor exam ☐ Pupils

Assessment to Perform:

- ☐ **Hemodynamic Monitoring** Frequency: Continuous Priority: Routine

Question(s):Measure: ☐ MAP ☐ CVP ☐ SVR ☐ SVV ☐ Cardiac Index

- ☐ **Drain care** Frequency: Until discontinued Priority: Routine

Question(s):

Drain 1:

Drain 2:

Drain 3:

Drain 4:

All Drains:

- ☐ **Lumbar drain care** Frequency: Until discontinued Priority: Routine

Question(s):

Lumbar drain mgmt:

- ☒ **Height and weight** Frequency: Once Frequency Limit: 1 Occurrences Priority: Routine Comments: On admission

- ☐ **Daily weights** Frequency: Daily Priority: Routine

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

☐ **Nasogastric tube insertion** Frequency: Once Priority: Routine

Question(s):

Type:

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

Question(s):

Tube Care Orders:

☐ **Oral care** Frequency: Every shift Priority: Routine

☐ **Nurse to advance mattress at first sign of Stage I or II decubitus ulcer per protocol** Frequency: Until discontinued Priority: Routine

☒ **Strict intake and output** Frequency: Every hour Priority: Routine

☒ **Dysphagia screen** Frequency: Once Priority: Routine

☐ **Straight cath** Frequency: Every 6 hours Priority: Routine Comments: If unable to void after second straight cath, insert Foley and call physician.

☐ **Insert/Maintain Foley and Notify**

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

Question(s):

Type:

Size:

Urinometer needed:

Indication:

Primary Ordering Comments:

Foley catheter may be removed per nursing protocol.

☒ **Foley catheter care** Frequency: Until discontinued Priority: Routine

Question(s):

Orders: Maintain

☒ **Notify Physician if Foley inserted** Frequency: Until discontinued Priority: Routine

☐ **No anticoagulants INcluding UNfractionated heparin** Frequency: Until discontinued Priority: Routine

Question(s):

Reason for "No" order: ☐ high risk of bleeding

☐ **No anti-platelet agents INcluding aspirin** Frequency: Until discontinued Priority: Routine

Question(s):

Reason for "No" order:

Nursing

☒ **Neurological assessment** Frequency: Every 15 min Priority: Routine

Question(s):

Assessment to Perform: ☐ Level of Consciousness ☐ Motor exam ☐ Pupils

Assessment to Perform:

☐ **Hemodynamic Monitoring** Frequency: Continuous Priority: Routine

Question(s):

Measure: ☐ MAP ☐ CVP ☐ SVR ☐ SVV ☐ Cardiac Index

☐ **Drain care** Frequency: Until discontinued Priority: Routine

Question(s):

Drain 1:

Drain 2:

Drain 3:

Drain 4:

All Drains:

☐ **Lumbar drain care** Frequency: Until discontinued Priority: Routine

Question(s):

Lumbar drain mgmt:

☒ **Height and weight** Frequency: Once Frequency Limit: 1 Occurrences Priority: Routine Comments: On admission

☐ **Daily weights** Frequency: Daily Priority: Routine

☐ **Nasogastric tube insertion** Frequency: Once Priority: Routine

Question(s):

Type:

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

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

Question(s):

Tube Care Orders:

☐ **Oral care** Frequency: Every shift Priority: Routine

☐ **Nurse to advance mattress at first sign of Stage I or II decubitus ulcer per protocol** Frequency: Until discontinued Priority: Routine

☒ **Strict intake and output** Frequency: Every hour Priority: Routine

☒ **Dysphagia screen** Frequency: Once Priority: Routine

☐ **Straight cath** Frequency: Every 6 hours Priority: Routine Comments: If unable to void after second straight cath, insert Foley and call physician.

☐ **Insert/Maintain Foley and Notify**

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

Question(s):

Type:

Size:

Urinometer needed:

Indication:

Primary Ordering Comments:

Foley catheter may be removed per nursing protocol.

☒ **Foley catheter care** Frequency: Until discontinued Priority: Routine

Question(s):

Orders: Maintain

☒ **Notify Physician if Foley inserted** Frequency: Until discontinued Priority: Routine

☐ **No anticoagulants INcluding UNfractionated heparin** Frequency: Until discontinued Priority: Routine

Question(s):

Reason for "No" order: ☐ high risk of bleeding

☐ **No anti-platelet agents INcluding aspirin** Frequency: Until discontinued Priority: Routine

Question(s):

Reason for "No" order:

Notify

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

Question(s):

Temperature greater than: ☐ 100 ☐ 100.5

Systolic BP less than: 90

Diastolic BP greater than: 100

Diastolic BP less than: 50

Heart rate greater than (BPM): 100

Heart rate less than (BPM): ☐ 50 ☐ 60

Respiratory rate greater than: 25

Respiratory rate less than: 8

SpO2 less than: 92

Temperature less than:

Systolic BP greater than: 160

MAP less than: 60.000

☒ **Notify Physician if acute change in neurological status** Frequency: Until discontinued Priority: Routine

☐ **Notify Physician of intrathecal medication to be delivered** Frequency: Until discontinued Priority: Routine

☐ **Notify Physician for changes in vasopressor orders** Frequency: Until discontinued Priority: Routine Comments: Including any additional vasopressor orders.

☐ **Notify Physician of the following:** Frequency: Until discontinued Priority: Routine Comments: Loss or new dampening of intracranial pressure waveform, drainage of new bright red blood, disconnection of intracranial pressure monitor, or drainage at intracranial pressure monitor site.

☐ **Notify Physician of any anti-epileptic medication levels** Frequency: Until discontinued Priority: Routine

☒ **Notify Physician of No Bowel Movement for more than 72 hours** Frequency: Until discontinued Priority: Routine

Diet

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

☐ **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.

☐ **NPO after midnight except meds Frequency:** Diet effective midnight **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 - Clear liquids Frequency:** Diet effective now **Priority:** Routine **Comments:** If patient passes Dysphagia screen.

Question(s):

Diet(s): ○ Clear Liquids

Cultural/Special:

Cultural/Special:

Other Options:

Other Options:

Advance Diet as Tolerated?

IDDSI Liquid Consistency:

Fluid Restriction:

Foods to Avoid:

Foods to Avoid:

☐ **Diet - Heart healthy Frequency:** Diet effective now **Priority:** Routine **Comments:** If patient passes Dysphagia screen.

Question(s):

Diet(s): ○ Heart Healthy

Cultural/Special:

Cultural/Special:

Other Options:

Other Options:

Advance Diet as Tolerated?

IDDSI Liquid Consistency:

Fluid Restriction:

Foods to Avoid:

Foods to Avoid:

☐ **Diet - 2000 Kcal/225 gm Carbohydrate Frequency:** Diet effective now **Priority:** Routine **Comments:** If patient passes Dysphagia screen.

Question(s):

Diet(s): ○ Consistent Carbohydrate

Consistent Carbohydrate: 2000 Kcal/225 gm Carbohydrate

Cultural/Special:

Cultural/Special:

Other Options:

Other Options:

Advance Diet as Tolerated?

IDDSI Liquid Consistency:

Fluid Restriction:

Foods to Avoid:

Foods to Avoid:

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

☐ **Diet Frequency:** Diet effective now **Priority:** Routine **Comments:** If patient passes Dysphagia screen.

Question(s):

Diet(s):

Cultural/Special:

Cultural/Special:

Other Options:

Other Options:

Advance Diet as Tolerated?

IDDSI Liquid Consistency:

Fluid Restriction:

Foods to Avoid:

Foods to Avoid:

☐ **Tube feeding Frequency:** Diet effective now **Priority:** Routine

Question(s):

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Formula:

Tube Feeding Schedule:

Tube Feeding Schedule:

Dietitian to manage Tube Feed?

Consent

☐ **Complete consent form Frequency:** Once **Priority:** Routine

Question(s):

Procedure:

Diagnosis/Condition:

Physician:

Risks, benefits, and alternatives (as outlined by the Texas Medical Disclosure Panel, as appears on Houston Methodist Medical/Surgical Consent forms) were discussed with patient/surrogate?

IV Fluids**IV Fluids**

- ☐ **sodium chloride 0.9 % infusion Dose:** .9 **Route:** intravenous **Frequency:** continuous
- ☐ **lactated Ringer's infusion Route:** intravenous **Frequency:** continuous
- ☐ **sodium chloride 0.9 % with potassium chloride 20 mEq/L infusion Dose:** 20 **Route:** intravenous **Frequency:** continuous
- ☐ **dextrose 5 % and sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion - for NPO Patients Dose:** 20 **Route:** intravenous **Frequency:** continuous
- ☐ **sodium chloride (HYPERTONIC) 3 % infusion Dose:** 3 **Route:** intravenous **Frequency:** continuous

Question(s):

RESTRICTED to Nephrology, Critical Care , Emergency Medicine, and Neurosurgery specialists. Are you a Nephrology, Critical Care, Emergency Medicine, or Neurosurgery specialist or ordering on behalf of one?

Medications**Medications - MISC.**

☐ **chlorhexidine (PERIDEX) 0.12 % solution Dose:** 15 mL **Route:** Mouth/Throat **Frequency:** every 4 hours while awake

Seizure Prophylaxis

- ☐ **levETIRAcetam (KEPPRA) tablet Dose:** 500 mg **Route:** oral **Frequency:** every 12 hours
- ☐ **levETIRAcetam (KEPPRA) IV Dose:** 500 mg **Route:** intravenous **Frequency:** every 12 hours

Question(s):

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

Vasospasm

- ☐ **niMODipine (NIMOTOP) capsule Dose:** 30 mg **Frequency:** Every 2 Hours (TIME CRITICAL) **Frequency Limit:** 21 Days

Admin Instructions:

For oral administration only. If patient unable to swallow capsules, call pharmacy.

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

☐ **niMODipine (NIMOTOP) capsule** Dose: 60 mg Route: oral Frequency: Every 4 Hours (TIME CRITICAL) Frequency Limit: 21 Days

Admin Instructions:

For oral administration only. If patient unable to swallow capsules, call pharmacy.

☐ **niMODipine (NYMALIZE) oral solution** Dose: 30 mg Route: oral Frequency: Every 2 Hours (TIME CRITICAL) Frequency Limit: 21 Days

☐ **niMODipine (NYMALIZE) oral solution** Dose: 60 mg Route: oral Frequency: Every 4 Hours (TIME CRITICAL) Frequency Limit: 21 Days

Anti-infectives

☐ **cefazolin (ANCEF) IV** Dose: 1 g 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:

☐ **cefepime (MAXIPIME) IV** Route: intravenous Frequency: every 8 hours Priority: STAT

Question(s):

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

Indication:

Admin Instructions:

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

☐ **metronidazole (FLAGYL)** 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:

☐ **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.

☐ **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.

ICP Elevation Management

☐ **mannitol 20 % injection** Dose: 1 g/kg Route: intravenous Frequency: once Frequency Limit: 1 Occurrences

Admin Instructions:

Continually monitor ICP, and contact provider for ICP > 20 for 5 minutes or longer.

Hold for serum sodium > 155, serum osmolality > 320.

Product Admin Instructions:

Administer via < or = 5 micron disc filter

☐ **Mannitol Q6H and Required Labs**

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

☒ **mannitol 25 % injection** Dose: 20 Route: intravenous Frequency: every 6 hours

Admin Instructions:

Continually monitor ICP, and contact provider for ICP > 20 for 5 minutes or longer.

Hold for serum sodium > 155, serum osmolality > 320.

Product Admin Instructions:

Administer via < or = 5 micron disc filter

☒ **Sodium level** Frequency: Every 6 hours Priority: Routine Specimen Type: Blood Maximum Quantity: 3 Comments:

Continue while patient is taking mannitol.

☒ **Osmolality, serum** Frequency: Every 6 hours Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Comments: Continue while patient is taking mannitol.

☒ **Notify Physician for (Specify lab)** Frequency: Until discontinued Priority: Routine

Question(s):

Other Lab (Specify): o serum sodium GREATER than 155 mEq/L or serum Osmolality greater than 320 mmol/L

BUN greater than:

Creatinine greater than:

Glucose greater than:

Glucose less than:

Hct less than:

Hgb less than:

LDL greater than:

Magnesium greater than (mg/dL):

Magnesium less than (mg/dL):

Platelets less than:

Potassium greater than (mEq/L):

Potassium less than (mEq/L):

PT/INR greater than:

PT/INR less than:

PTT greater than:

PTT less than:

Serum Osmolality greater than:

Serum Osmolality less than:

Sodium greater than:

Sodium less than:

WBC greater than:

WBC less than:

☐ **Sodium chloride concentrated injection (23.4%) IV syringe for elevated intracranial pressure + Required Labs**

☒ **Sodium chloride concentrated injection (23.4%) IV syringe+ NS Flush Panel**

☒ **sodium chloride concentrated injection (23.4%) for elevated intracranial pressure (RESTRICTED)** Dose: 120

mEq Route: intravenous Frequency: once Frequency Limit: 1 Occurrences Priority: STAT Minimum Infusion

Duration: 10.000 Minutes

Question(s):

RESTRICTED to Neurosurgery and Neuro ICU intensivists. Are you a Neurosurgery or Neuro ICU intensivist or ordering on behalf of one?

Admin Instructions:

For administration through SYRINGE PUMP ADAPTER over 10 minutes. Monitor heart rate and blood pressure at bedside for duration of infusion. Consider continuous ICP monitoring for more than one dose and contact provider for ICP GREATER THAN 20cmH2O for 5 minutes or longer. Contact for sodium GREATER THAN 155 mEq/L.

Product Admin Instructions:

Administer via central line only.

☒ **sodium chloride 0.9% flush** Dose: 10 mL Route: intravenous Frequency: once Frequency Limit: 1

Occurrences

Admin Instructions:

Flush for 23.4% sodium chloride

☒ **Sodium level** Frequency: Every 6 hours Frequency Limit: 4 Occurrences Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **sodium chloride 3% infusion + Required Labs**

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

☒ **sodium chloride (HYPERTONIC) 3 % infusion** Dose: 3 Route: intravenous Frequency: continuous

Question(s):

RESTRICTED to Nephrology, Critical Care , Emergency Medicine, and Neurosurgery specialists. Are you a Nephrology, Critical Care, Emergency Medicine, or Neurosurgery specialist or ordering on behalf of one?

Admin Instructions:

Continually monitor ICP, and contact provider for ICP greater than 20 for 5 minutes or longer. Continually monitor ICP, and contact provider for ICP greater than 20 for 5 minutes or longer.

☒ **Sodium level** Frequency: Every 6 hours Priority: Routine Specimen Type: Blood Maximum Quantity: 3 Comments: Continue while patient is on a sodium chloride 3% infusion.

☒ **Osmolality, serum** Frequency: Every 6 hours Priority: Routine Specimen Type: Blood Maximum Quantity: 3 Comments: Continue while patient is on a sodium chloride 3% infusion.

☒ **Notify Physician for (Specify lab)** Frequency: Until discontinued Priority: Routine

Question(s):

Other Lab (Specify): ☐ serum sodium GREATER than 155 mEq/L or serum Osmolality greater than 320 mmol/L

BUN greater than:

Creatinine greater than:

Glucose greater than:

Glucose less than:

Hct less than:

Hgb less than:

LDL greater than:

Magnesium greater than (mg/dL):

Magnesium less than (mg/dL):

Platelets less than:

Potassium greater than (mEq/L):

Potassium less than (mEq/L):

PT/INR greater than:

PT/INR less than:

PTT greater than:

PTT less than:

Serum Osmolality greater than:

Serum Osmolality less than:

Sodium greater than:

Sodium less than:

WBC greater than:

WBC less than:

Medications - Bowel Managment

☒ **polyethylene glycol (MIRALAX) packet** Dose: 17 g Route: oral Frequency: 2 times daily

Product Admin Instructions:

Mix in 4-8oz of water.

☒ **Stool Softener Options**

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

☐ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per tablet** Dose: 2 tablet Route: oral Frequency: nightly

IV Infusions - Vasopressors

☐ **phenylephrine (NEO-SYNEPHRINE) infusion** Frequency: titrated Priority: STAT

☐ **DOPamine IV infusion** Frequency: titrated Priority: STAT

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

☐ **vasopressin (PITRESSIN) infusion** Dose: 0.01 - 0.04 Units/min Route: intravenous Frequency: continuous Priority: STAT

Admin Instructions:

Initiate vasopressin infusion at 0.01 units/min.

Titrate by 0.01 units/min to keep mean arterial pressure above *** millimeters of mercury.

Antihypertensives - IV Infusion

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

Antihypertensives - PRN

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

☒ **hydrALAZINE (APRESOLINE) injection** Dose: 10 mg Route: intravenous Frequency: every 6 hours PRN

Question(s):

BP HOLD parameters for this order:

Contact Physician if:

Admin Instructions:

Administer if Systolic BP GREATER than ***

☐ **labetalol (TRANDATE) injection** Dose: 10 mg Route: intravenous Frequency: every 15 min PRN PRN Comment: systolic blood pressure greater than 160 mm of mercury

Question(s):

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

BP & HR HOLD for: Heart Rate LESS than 60 bpm

Admin Instructions:

Hold for a heart rate of less than 60 beats per minute. Notify MD if 3 successive doses are administered.

☐ **metoprolol (LOPRESSOR) injection** Dose: 5 mg Route: intravenous Frequency: every 6 hours PRN PRN Comment: systolic blood pressure greater than 160 mm of mercury

Question(s):

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

BP & HR HOLD for: Heart Rate LESS than 60 bpm

Contact Physician if:

Admin Instructions:

Hold for heart rate less than 60 beats per minute.

☐ **enalaprilat (VASOTEC) injection** Dose: 1.25 mg Route: intravenous Frequency: every 6 hours PRN PRN Comment: systolic blood pressure greater than 160 mm of mercury

Question(s):

BP HOLD parameters for this order:

Contact Physician if:

PRN Medications - Insomnia

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

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

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

PRN Medications - Insomnia

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

PRN Medications - Bowel Management

☐ **magnesium hydroxide suspension** Dose: 30 mL Frequency: daily PRN PRN Reasons: constipation

Admin Instructions:

Give scheduled until bowel movement.

☐ **bisacodyl (DULCOLAX) EC tablet** Dose: 10 mg Route: oral Frequency: nightly PRN PRN Reasons: constipation

Admin Instructions:

Give scheduled until bowel movement.

☐ **bisacodyl (DULCOLAX) suppository** Dose: 10 mg Route: rectal Frequency: nightly PRN PRN Reasons: constipation

Admin Instructions:

Give scheduled until bowel movement.

☐ **milk and molasses enema** Dose: 30 mL Route: rectal Frequency: daily PRN PRN Comment: constipation

Admin Instructions:

FOR RECTAL USE ONLY. SHAKE IF SEPARATED.

PRN Medications - Bowel Management

☐ **saline,mineral oil,glycerin (S.M.O.G.) enema** Dose: 180 mL Frequency: once

Admin Instructions:

FOR RECTAL USE.

PRN Medications - Fever Management

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

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

☒ **acetaminophen (TYLENOL) tablet** Dose: 650 mg Route: oral Frequency: every 6 hours PRN PRN Reasons: mild pain (score 1-3) fever

Question(s):

Allowance for Patient Preference:

Product Admin Instructions:

Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

☒ **acetaminophen (TYLENOL)suspension** Dose: 650 mg Route: oral Frequency: every 6 hours PRN PRN Reasons: mild pain (score 1-3) fever

Question(s):

Allowance for Patient Preference:

Admin Instructions:

Use if patient cannot swallow tablet.

☒ **acetaminophen (TYLENOL) suppository** Dose: 650 mg Route: rectal Frequency: every 6 hours PRN PRN Reasons: mild pain (score 1-3) fever

Admin Instructions:

Utilize this order to administer acetaminophen suppository if patient cannot use oral tablet or liquid formulation.

Product Admin Instructions:

Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

PRN Medications - Antiemetics: For Patients LESS than 65 years old

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

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

Admin Instructions:

Give if patient is able to tolerate oral medication.

Product Admin Instructions:

May cause QTc prolongation.

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

Admin Instructions:

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

Product Admin Instructions:

May cause QTc prolongation.

☐ **ondansetron (ZOFTRAN) 8 mg, dexamethasone (DECADRON) 8 mg in sodium chloride 0.9 % 50 mL IVPB (Use caution when using in pituitary patients)** Route: intravenous Frequency: once PRN PRN Reasons: nausea

Product Admin Instructions:

May cause QTc prolongation.

☐ **scopolamine (TRANSDERM-SCOP) 1.5 mg (1 mg over 3 days) - For Patients LESS than 65 years old** Dose: 1 patch Route: transdermal Frequency: every 72 hours

PRN Medications - Antiemetics: For Patients GREATER than or EQUAL to 65 years old

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

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

Admin Instructions:

Give if patient is able to tolerate oral medication.

Product Admin Instructions:

May cause QTc prolongation.

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

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

Reasons: nausea

vomiting

Admin Instructions:

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

Product Admin Instructions:

May cause QTc prolongation.

☐ **ondansetron (ZOFTRAN) 8 mg, dexamethasone (DECADRON) 8 mg in sodium chloride 0.9 % 50 mL IVPB (Use caution when using in pituitary patients)** Route: intravenous Frequency: once PRN PRN Reasons: nausea

Product Admin Instructions:

May cause QTc prolongation.

PRN Medications - Eye/Sinus 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)

☐ **artificial tears 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

☐ **sodium chloride (OCEAN) 0.65 % nasal spray** Dose: 2 spray Route: Each Naris Frequency: every 6 hours PRN PRN

Comment: nasal stuffiness

☐ **sodium chloride 0.9% bag for line care**

☒ **sodium chloride 0.9 % bag for line care** Dose: .9 Frequency: PRN PRN Reasons: line care

Admin Instructions:

For flushing of extension tubing sets after administration of intermittent infusions. Program sodium chloride bag to run at the same infusion rate as medication given for a total volume equal to contents of tubing sets used. Change bag every 24 hours.

VTE

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

VTE Risk and Prophylaxis Tool (Required)

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

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

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

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

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

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

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

Question(s):

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

☒ **Place sequential compression device**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

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

Question(s):

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

☒ **Place sequential compression device**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

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

Question(s):

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

☒ **Place sequential compression device**

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

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

Question(s):

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

☒ **Place sequential compression device**

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

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

☐ **LOW Risk of VTE (Required)**

☒ **Low Risk (Required)**

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

Question(s):

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

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

☒ **Moderate Risk (Required)**

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

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

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

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

Question(s):

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

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

Question(s):

Side: Bilateral

Select Sleeve(s):

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

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

Question(s):

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

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

Question(s):

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

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

Patient renal status: @CRCL@

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

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

☐ **ENOXAPARIN 30 MG DAILY**

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

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

Start Date: S+1

Question(s):

Indication(s):

Product Admin Instructions:

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

☐ **ENOXAPARIN SQ DAILY**

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

Question(s):

Indication(s):

Product Admin Instructions:

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

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

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.

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

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)

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** (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

Routine

Question(s):

Indication:

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

☐ **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	

Sign: _____ Printed Name: _____

Date/Time: _____

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

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

☒ **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**

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

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):

Labs

Labs

- ☐ **Blood gas, arterial** Frequency: STAT Frequency Limit: 1 Occurrences Priority: Routine Specimen Type: Blood Maximum Quantity: 3
- ☐ **Type and screen** Frequency: Once Priority: Routine Specimen Type: Blood
- ☒ **Basic metabolic panel** 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
- ☒ **CBC with platelet and differential** 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.

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

☐ **Platelet function analysis** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Primary Ordering Comments:

Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

☐ **Platelet function P2Y12** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

Primary Ordering Comments:

Draw discard blue top first. BTO tube from Lab. Fill to line. Walk to Lab STAT.

☐ **Hemoglobin A1c** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Bedside Glucose and Notify** (Required)

☒ **Bedside glucose** Frequency: Once Priority: Routine Specimen Type: Blood

☒ **Notify Physician of bedside blood glucose greater than** Frequency: Until discontinued Priority: Routine

☒ **Bedside Glucose and Notify** (Required)

☒ **Bedside glucose** Frequency: Once Priority: Routine Specimen Type: Blood

☒ **Notify Physician of bedside blood glucose greater than** Frequency: Until discontinued Priority: Routine

☐ **Bedside Glucose and Notify** (Required)

☒ **Bedside glucose** Frequency: Once Priority: Routine Specimen Type: Blood

☒ **Notify Physician of bedside blood glucose greater than** Frequency: Until discontinued Priority: Routine

☐ **Phenytoin level, free** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

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

☐ **Testosterone, total, immunoassay (for adult males)** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

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

Primary Ordering Comments:

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

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

☐ **Follicle stimulating hormone** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

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

☐ **Cortisol level, AM** Frequency: AM draw Frequency Limit: 1 Occurrences Priority: Routine Specimen Type: Blood Maximum Quantity: 3

☐ **Cortisol level, random** Frequency: Once Priority: Routine Specimen Type: Blood Maximum Quantity: 3

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

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

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

Microbiology

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

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

Most recent Blood Culture results from the past 7 days:

@LASTPROCRESULT(LAB462)@

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

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.

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

Cardiology

Cardiology

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

Question(s):

Clinical Indications: ☐ Pre-Op Clearance

Interpreting Physician:

☐ **Echocardiogram complete w contrast and 3D if needed** 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.

☐ **PV duplex venous lower extremity bilat** Frequency: 1 time imaging Priority: Routine

Question(s):

Laterality:

☐ **PV duplex venous lower extremity left** Frequency: 1 time imaging Priority: Routine

☐ **PV duplex venous lower extremity right** Frequency: 1 time imaging Priority: Routine

Cardiology

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

Question(s):

Clinical Indications: ☐ Pre-Op Clearance

Interpreting Physician:

☐ **Echocardiogram complete w contrast and 3D if needed** 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**Diagnostic MRI/MRA**

☐ **MRI Brain W Wo Contrast** Frequency: 1 time imaging Priority: Routine

Question(s):

Special Brain protocol requested?

What are the patient's sedation requirements?

Is the patient pregnant?

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

Process Instructions:

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRI Brain Wo Contrast Frequency:** 1 time imaging **Priority:** Routine

Question(s):

Special Brain protocol requested?

Is this scan to monitor for ARIA during an Alzheimer Therapy?

ARIA Alzheimer therapy:

What are the patient's sedation requirements?

Is the patient pregnant?

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

Process Instructions:

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRA Head Wo Contrast Frequency:** 1 time imaging **Priority:** Routine

Question(s):

What are the patient's sedation requirements?

Is the patient pregnant?

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

Process Instructions:

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRA Neck Wo Contrast Frequency:** 1 time imaging **Priority:** Routine

Question(s):

What are the patient's sedation requirements?

Is the patient pregnant?

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

Process Instructions:

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRI Cervical Spine Wo Contrast Frequency:** 1 time imaging **Priority:** Routine**Question(s):**

What are the patient's sedation requirements?

Is the patient pregnant?

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

Process Instructions:

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRI Thoracic Spine Wo Contrast Frequency:** 1 time imaging **Priority:** Routine**Question(s):**

What are the patient's sedation requirements?

Is the patient pregnant?

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

Process Instructions:

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

☐ **MRI Lumbar Spine Wo Contrast Frequency:** 1 time imaging **Priority:** Routine**Question(s):**

What are the patient's sedation requirements?

Is the patient pregnant?

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

Process Instructions:

Patients 60yrs and older will need a creatine drawn for mri exams order with and without contrast, or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

Patients younger than 60 yrs history of diabetes, HTN, renal impairment will also need creatine drawn for mri exams with and without or with contrast only. Creatine results can be accepted if within 6 weeks from date of exam.

MRCP exams patient should be NPO 6-8hrs prior to exam.

Patients needing IV sedation should be NPO 6-8hrs prior to exam.

Patients needed General Anesthesia should be NPO 8hrs prior to exam.

If patient is allergic to Gadolinium please contact radiologist for prophylactic instructions if mri exam is ordered with IV contrast.

CT

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

Question(s):

Does this require fiducials?

Is the patient pregnant?

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

☐ **CT Head Wo Contrast in AM Frequency:** 1 time imaging **Start Date:** S+1 **Start Time:** 0400 **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.):

☐ **CT Cervical Spine Wo Contrast 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.):

☐ **CT Thoracic Spine Wo Contrast 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.):

☐ **CT Lumbar Spine Wo Contrast 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.):

☐ **CTA Head W Wo Contrast Frequency:** 1 time imaging **Priority:** Routine

Question(s):

Is the patient pregnant?

Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.

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

Process Instructions:

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

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

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

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

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

☐ **CTA Neck W Wo Contrast Frequency:** 1 time imaging **Priority:** Routine

Question(s):

Is the patient pregnant?

Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.

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

Process Instructions:

Patients with a known Iodine contrast allergy will require review by the radiologist.

Fasting for this test is not required.

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

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

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

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

Diagnostic X-ray

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

☐ **Chest 2 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.):

☐ **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.):

☐ **VP Shunt Series** (Required)

☒ **XR Shunt Series Chest and Abdomen 2 Views 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.):

☒ **XR Shunt Series Head and Neck 2 Views 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.):

Other Studies**Other Diagnostic Studies**

☐ **Angiogram Cerebral Bilateral Frequency:** 1 time imaging **Priority:** Routine **Comments:** 4 vessel angiogram

Question(s):

What is the expected date for Procedure?

Please select the preferred Artery access for this procedure, if known? (leave blank for Physician Performing procedure to decide):

Is the patient pregnant?

What is the patient's sedation requirements?

Physician contact number:

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

Process Instructions:

Patient cannot eat or drink after midnight on the night before the procedure (must be a minimum of 8 hours prior to the procedure). Patient may take small sips of water with his/her usual medications. Please see special instructions below for diabetic patients or

patients currently taking blood-thinners or anti-coagulants.

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

If the patient is diabetic:

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

If the patient is currently taking blood-thinners or anti-coagulants:

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

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

☐ **PV Transcranial Doppler intracranial arteries complete Frequency:** 1 time imaging **Frequency Limit:** 6 Occurrences

Priority: Routine **Comments:** Perform Monday, Wednesday, Friday or three alternating days of a week for two consecutive weeks.

Question(s):

Special protocol:

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

☐ **Continuous EEG monitoring** Frequency: Daily imaging Frequency Limit: 7 Days Priority: Routine

Question(s):

Testing Location: At Bedside (Patients Room)

Testing Duration: Until D/C Ordered

Record Video? Yes

Clinical Indication:

Process Instructions:

STAT vs. Routine criteria - A STAT order should be placed by a physician when the patient:

-Has an altered mental status

-Suspected status epilepticus or

-Pending discharge

If the patient does not meet this criteria, please consider ordering a routine study. All efforts will be made to complete routine studies within 24 hours.

Neurophysiology Lab (ext. 23104) is open M – F, 6am – 6pm and Sat/Sun, 8am – 12pm. If a STAT is ordered after normal business hours, the study must be called in to Specialty Care Agency at 1-800-305-6234 (Account #3551). Please be ready to provide patient's name, MRN, room number, and type of study (Routine / Continuous).

For all STAT and Routine patients, please ensure:

1. The patient is still and/or cooperative. Please discuss sedation prior to this study.

2. The patient's scalp must be accessible. Please make arrangements to remove bandages, tape, hair pieces or wigs prior to the study.

3. All interruptions must be minimized while the study is in progress.

4. If possible, the patient should not have caffeine or nicotine for at least eight (8) hours prior to the study.

Other Diagnostic Studies

☐ **Angiogram Cerebral Bilateral** Frequency: 1 time imaging Priority: Routine Comments: 4 vessel angiogram

Question(s):

What is the expected date for Procedure?

Please select the preferred Artery access for this procedure, if known? (leave blank for Physician Performing procedure to decide):

Is the patient pregnant?

What is the patient's sedation requirements?

Physician contact number:

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

Process Instructions:

Patient cannot eat or drink after midnight on the night before the procedure (must be a minimum of 8 hours prior to the procedure). Patient may take small sips of water with his/her usual medications. Please see special instructions below for diabetic patients or patients currently taking blood-thinners or anti-coagulants.

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

If the patient is diabetic:

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

If the patient is currently taking blood-thinners or anti-coagulants:

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

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

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

☐ **Continuous EEG monitoring** Frequency: Daily imaging Frequency Limit: 7 Days Priority: Routine

Question(s):

Testing Location: At Bedside (Patients Room)

Testing Duration: Until D/C Ordered

Record Video? Yes

Clinical Indication:

Process Instructions:

STAT vs. Routine criteria - A STAT order should be placed by a physician when the patient:

-Has an altered mental status

-Suspected status epilepticus or

-Pending discharge

If the patient does not meet this criteria, please consider ordering a routine study. All efforts will be made to complete routine studies within 24 hours.

Neurophysiology Lab (ext. 23104) is open M – F, 6am – 6pm and Sat/Sun, 8am – 12pm. If a STAT is ordered after normal business hours, the study must be called in to Specialty Care Agency at 1-800-305-6234 (Account #3551). Please be ready to provide patient's name, MRN, room number, and type of study (Routine / Continuous).

For all STAT and Routine patients, please ensure:

1. The patient is still and/or cooperative. Please discuss sedation prior to this study.

2. The patient's scalp must be accessible. Please make arrangements to remove bandages, tape, hair pieces or wigs prior to the study.

3. All interruptions must be minimized while the study is in progress.

4. If possible, the patient should not have caffeine or nicotine for at least eight (8) hours prior to the study.

Respiratory**Respiratory**

☐ **Incentive spirometry instructions** Frequency: Once Frequency Limit: 1 Occurrences Priority: Routine

Question(s):

Frequency of use: ○ Every hour while awake

☐ **Oxygen therapy - Nasal cannula** Frequency: Continuous Priority: Routine

Question(s):

Initial Device: ○ Nasal Cannula

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)@

☐ **Oxygen therapy - Simple face mask** Frequency: Continuous Priority: Routine

Question(s):

Initial Device: ○ Simple Face Mask

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)@

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

Question(s):

Mechanical Ventilation:

Vent Management Strategies: Adult Respiratory Ventilator Protocol

Rehab**Consults**

For Physician Consult orders use sidebar

Ancillary Consults

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

☐ **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): ☐ Post Neuromuscular or Musculoskeletal Surgery Care.

Are there any restrictions for positioning or mobility?

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

Weight Bearing Status:

Reason for PT?

Process Instructions:

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

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

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

Question(s):

Special Instructions:

Location of Wound?

Reason for PT?

☒ **Consult OT Eval and Teat** Frequency: Once Priority: Routine

Question(s):Reason for referral to Occupational Therapy (mark all that apply): ☐ Decline in Activities of Daily Living performance from baseline (bathing, dressing, toileting, grooming)

Are there any restrictions for positioning or mobility?

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

Weight Bearing Status:

Reason for OT?

Process Instructions:

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

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

☐ **Consult to Nutrition Services** Frequency: Once Priority: Routine

Question(s):

Reason For Consult?

Purpose/Topic:

Reason for Consult?

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

Question(s):

Reason for consult?

Reason for Consult?

Process Instructions:

For requests after hours, call the house operator.

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

Question(s):

Reason for consult:

Reason for SLP?

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

☐ **Consult to Wound Ostomy Care Nurse** Frequency: Once Priority: Routine

Question(s):

Reason for consult:

Reason for consult:

Reason for consult:

Reason for consult:

Consult for NPWT:

Reason for consult:

Reason for consult:

Reason for Consult?

Process Instructions:

This is NOT for PT Wound Care Consult order.

☐ **Consult to Respiratory Therapy** Frequency: Once Priority: Routine

Question(s):

Reason for Consult?

Reason for Consult?

☐ **Music Therapy/Art therapy consult - eval & treat** Frequency: Once Priority: Routine

Question(s):

Request Date: TODAY

Therapy Requested:

Please Indicate REASON FOR REFERRAL (check all that apply):

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): ☐ Post Neuromuscular or Musculoskeletal Surgery Care.

Are there any restrictions for positioning or mobility?

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

Weight Bearing Status:

Reason for PT?

Process Instructions:

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

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

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

Question(s):

Special Instructions:

Location of Wound?

Reason for PT?

☒ **Consult OT Eval and Teat** Frequency: Once Priority: Routine

Question(s):Reason for referral to Occupational Therapy (mark all that apply): ☐ Decline in Activities of Daily Living performance from baseline (bathing, dressing, toileting, grooming)

Are there any restrictions for positioning or mobility?

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

Weight Bearing Status:

Reason for OT?

Process Instructions:

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

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

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

☐ **Consult to Nutrition Services** Frequency: Once Priority: Routine

Question(s):

Reason For Consult?

Purpose/Topic:

Reason for Consult?

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

Question(s):

Reason for consult?

Reason for Consult?

Process Instructions:

For requests after hours, call the house operator.

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

Question(s):

Reason for consult:

Reason for SLP?

☐ **Consult to Wound Ostomy Care Nurse** Frequency: Once Priority: Routine

Question(s):

Reason for consult:

Reason for consult:

Reason for consult:

Reason for consult:

Consult for NPWT:

Reason for consult:

Reason for consult:

Reason for Consult?

Process Instructions:

This is NOT for PT Wound Care Consult order.

☐ **Consult to Respiratory Therapy** Frequency: Once Priority: Routine

Question(s):

Reason for Consult?

Reason for Consult?

Physician Consults

☐ **Consult Intensive Care** Frequency: Once Priority: Routine

Question(s):

Provider Group:

Reason for Consult?

Patient/Clinical information communicated?

Patient/clinical information communicated?

To Provider:

Provider Group:

☐ **Consult Physical Medicine Rehab** Frequency: Once Priority: Routine

Question(s):

Provider Group:

Reason for Consult?

Patient/Clinical information communicated?

Patient/clinical information communicated?

To Provider:

Provider Group:

☐ **Consult Internal Medicine** Frequency: Once Priority: Routine

Question(s):

Provider Group:

Reason for Consult?

Patient/Clinical information communicated?

Patient/clinical information communicated?

To Provider:

Provider Group:

Additional Orders