Location: _____

General

Nursing

Nursing

For patients who require short-term urinary catheterization, avoid the routine use of antimicrobial-coated urinary catheters to prevent UTIs.
For patients with suspected catheter-associated UTI who are unable to tolerate the permanent removal of an indwelling urinary catheter, consider the use of a suprapubic urinary catheter.
For patients with suspected catheter-associated UTIs, consider removing indwelling urinary catheters.

- ☐ **Telemetry**

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

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

- ☐ **Neuro checks** **Frequency:** Every 4 hours **Priority:** Routine
- ☐ **Height and weight** **Frequency:** Once **Priority:** Routine
- ☐ **Daily weights** **Frequency:** Daily **Priority:** Routine
- ☐ **Intake and Output** **Frequency:** Every shift **Priority:** Routine
- ☐ **Apply cooling blanket** **Frequency:** As needed **Priority:** Routine **Comments:** Cooling measures
- ☐ **IV access care** **Frequency:** Per unit protocol **Priority:** Routine **Comments:** Remove peripheral IV upon transfer from unit
- ☐ **Insert and maintain Foley**

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

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

- ☐ **Straight cath** **Frequency:** Once **Priority:** Routine
- ☐ **Remove Foley catheter** **Frequency:** Once **Priority:** Routine

Notify

- ☐ **Notify Physician (Specify)** **Frequency:** Until discontinued **Priority:** Routine

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

☐ **Notify Physician for (Specify lab)** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
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:
Other Lab (Specify):

☑ **Notify Physician (Specify vitals,output,pulse ox)** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Temperature greater than: 100.5
Temperature less than:
Systolic BP greater than: 160
Systolic BP less than: 90
Diastolic BP greater than: 100
Diastolic BP less than: 50
MAP less than: 60.000
Heart rate greater than (BPM): 100
Heart rate less than (BPM): 60
Respiratory rate greater than: 25
Respiratory rate less than: 8
SpO2 less than: 92

Diet

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

IV Fluids

Peripheral IV Access

☐ **Initiate and maintain IV**

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

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

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

IV Bolus

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

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

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

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

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

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

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

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

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

Maintenance IV Fluids

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

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

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

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

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

Medications

For appropriately selected patients with complicated UTI and clinically severe infection, treat with antibacterial agents to complete a treatment course of 14 days in total.

For appropriately selected patients with complicated UTIs (eg, men who are febrile, patients who may have bladder outlet obstruction, patients with indwelling catheters), treat with antibacterial agents to complete a treatment course of 7 to 14 days in total

For patients with a Gram-positive organism seen on the initial Gram stain, use an aminopenicillin plus a beta-lactamase inhibitor for 7 days as first-line therapy, with or without a single parenteral dose of an antibacterial agent

For patients with more severe cases of acute pyelonephritis, treat with antibacterial agents to complete a treatment course of 7 to 14 days in total

Beta Lactamase Inhibitors

☐ **piperacillin-tazobactam (ZOSYN) IV Dose:** 3.375 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:
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.

Carbapenems

☐ **ertapenem (INVanz) IV Dose:** 1 g **Route:** intravenous **Frequency:** every 24 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:
Product Admin Instructions:
ERTApenem must not be mixed or Y-sited into any Dextrose-containing solutions. Flush IV line with Normal Saline before and after administration.

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

Cephalosporins 3rd Generation

☐ **ceftriaxone (ROCEPHIN) IV Dose:** 1 g **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication:
Product Admin Instructions:
Avoid infusion of ceftriaxone with calcium-containing solutions (such as Lactated Ringer's) as precipitation may occur

☐ **cefepime (MAXIPIME) 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:
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.

Aminoglycosides

☐ **gentamicin (GARAMYCIN) IVPB Dose:** 5 mg/kg **Route:** intravenous **Frequency:** every 24 hours **Priority:** STAT
Question(s):
Indication:

Antiemetics

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

◉ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN
PRN Reasons: nausea
vomiting
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
May cause QTc prolongation.

◉ **ondansetron (ZOFRAN) 4 mg/2 mL injection Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Product Admin Instructions:
May cause QTc prolongation.

☐ **promethazine (PHENERGAN)**

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

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

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

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

Antiemetics

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

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

◉ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
May cause QTc prolongation.

◉ **ondansetron (ZOFRAN) 4 mg/2 mL injection Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Product Admin Instructions:
May cause QTc prolongation.

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

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

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

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

Antiemetics

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

◉ **ondansetron ODT (ZOFRAN-ODT) disintegrating tablet Dose:** 4 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
May cause QTc prolongation.

◉ **ondansetron (ZOFRAN) 4 mg/2 mL injection Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Admin Instructions:
Give if patient is UNable to tolerate oral medication OR if a faster onset of action is required.
Product Admin Instructions:
May cause QTc prolongation.

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

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

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

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

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

Antipyretics

☐ **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).

VTE

Labs

Labs Today

☐ **Blood gas, arterial Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☐ **CBC and differential Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

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

☐ **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)@

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

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

☑ **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.

Cardiology
Imaging
CT

☐ **CT Renal Stone Protocol** **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 Abdomen with IV and PO Contrast (Omnipaque)**
For those with iodine allergies, please order the panel with Readi-Cat (barium sulfate).

☑ **CT Abdomen W Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.
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.

☑ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** **Dose:** 300 **Frequency:** once
Admin Instructions:
FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

☐ **CT Abdomen and Pelvis with IV and PO Contrast (Omnipaque)**
For those with iodine allergies, please order the panel with Readi-Cat (barium sulfate).

☑ **CT Abdomen Pelvis W Contrast** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the patient pregnant?
Can the Creatinine labs be waived prior to performing the exam? No, all labs must be obtained prior to performing this exam.
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.

☑ **iohexol (OMNIPAQUE) 300 mg iodine/mL oral solution** **Dose:** 300 **Frequency:** once
Admin Instructions:
FOR CT SCAN ONLY: Mix Iohexol 30 mL in 32 ounces of water, may add one packet of Crystal Light flavored to taste.

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

X-Ray

☐ **Kub Kidney Ureter Bladder** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Reason for Exam: Flank pain
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **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.):

US

☐ **US Renal** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Is the Ultrasound on a native kidney?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Other Diagnostic Studies

Respiratory

Rehab

Consults

Consults

☐ **Consult Infectious Diseases** **Frequency:** Once **Priority:** Routine
Question(s):
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

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