Location: _____

General

Precautions

☐ **Fall precautions** **Frequency:** Continuous **Priority:** Routine **Comments:** On Admission, q shift and changes in patient condition
Question(s):
Increased observation level needed:

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

☐ **Seizure precautions** **Frequency:** Continuous **Priority:** Routine **Comments:** Initiate seizure/ PIH precautions
Question(s):
Increased observation level needed:

ERAS Pathway

Scheduled Pain Medications

☐ **ibuprofen (ADVIL) tablet** **Dose:** 800 mg **Route:** oral **Frequency:** every 8 hours scheduled
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

☐ **acetaminophen (TYLENOL) tablet** **Dose:** 1000 mg **Route:** oral **Frequency:** every 8 hours scheduled **Frequency Limit:** 4 Days
Question(s):
Allowance for Patient Preference:

Panel Orders

Postpartum Condition Specific Orders

☐ **Magnesium Sulfate OB Panel**

☑ **Vital Signs**

☑ **Vital signs - T/P/R/BP** **Frequency:** Every 15 min **Priority:** Routine **Comments:** Obtain BP, HR and RR every 15 minutes x 1 hour, then every 30 minutes x 1 hour, then hourly.

☑ **Pulse oximetry continously throughout the first 2 hours** **Frequency:** Every hour **Priority:** Routine **Comments:** Monitor continuously for the first two hours of administration and then check every 1 hour while assessing vital signs. Notify MD if SaO2 is less than 94%
Question(s):
Current FIO2 or Room Air:

☑ **Nursing**

☑ **Assess breath sounds** **Frequency:** Every 2 hours **Priority:** Routine **Comments:** Monitor maternal respiratory effort and breath sounds every 2 hours. Notify physician for shortness of breath or tightness in chest.
Question(s):
Assess: ○ breath sounds

☑ **Assess for Magnesium Toxicity** **Frequency:** Every 15 min **Start Date:** S **Priority:** Routine **Comments:** Monitor and document. Acquire a baseline measurement prior to infusion therapy, then assess deep tendon reflex's (DTR), level of consciousness (LOC) and orientation, clonus, headache, visual disturbances, nausea/vomiting, and epigastric pain every 15 minutes times 1 hour, then every 30 minutes times 1 hour. Following the first two hours of magnesium infusion monitor DTR's and clonus every 2 hours or per physician order. Notify physician for decreased or absent deep tendon reflexes.

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

☐ **Toileting - Bedside commode** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Specify:

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

☑ **Limit total IV fluid intake to 125 cc/hr** **Frequency:** Until discontinued **Priority:** Routine

☐ **Insert and maintain Foley**

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

☑ **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

☐ **Activity**

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

☑ **Bed rest with bathroom privileges** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Bathroom Privileges: ○ with bathroom privileges

☐ **Bed rest with bathroom privileges for BM only** **Frequency:** Until discontinued **Priority:** Routine **Comments:**
For bowel movement only
Question(s):
Bathroom Privileges: ○ with bathroom privileges

☐ **Diet**

☐ **NPO** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
NPO:
Pre-Operative fasting options:
Process Instructions:
An NPO order without explicit exceptions means nothing can be given orally to the patient.

☑ **NPO with ice chips** **Frequency:** Diet effective now **Priority:** Routine **Comments:** 1/2 cup per hour
Question(s):
NPO: ○ Except Ice chips
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
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:

☑ **Notify**

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

☑ **Notify Physician for validated vitals: Frequency:** Until discontinued **Priority:** Routine **Comments:** For validated vital signs and for urine output less than 30 milliliters per hour
Question(s):
Temperature greater than: ○ 100.3 ○ 100.5
Respiratory rate less than: ○ 10 ○ 8
SpO2 less than: ○ 95 ○ 92
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

☑ **Notify Physician for magnesium Frequency:** Until discontinued **Priority:** Routine
Question(s):
Magnesium greater than (mg/dL): ○ 8
Magnesium less than (mg/dL): ○ 4
BUN greater than:
Creatinine greater than:
Glucose greater than:
Glucose less than:
Hct less than:
Hgb less than:
LDL greater than:
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):

☑ **IV Fluids**

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

☑ **Magnesium Sulfate**

○ **Magnesium Sulfate 6 gm Loading and Maintenance Infusion**

DISCONTINUE INFUSION AND CALL PROVIDER IF SYMPTOMS OF MAGNESIUM TOXICITY ARE PRESENT.

☑ **Monitor for signs/symptoms of Magnesium Toxicity: decreased or absent DTRs, decreased or changes in level of consciousness, decreased respiratory rate (less than 10 breaths/minute), oliguria (less than 30 milliliters/hour), shortness of breath or tightness in chest Frequency:** Until discontinued **Priority:** Routine

☑ **magnesium sulfate 6 gm IV Loading Dose + Maintenance infusion**

☑ **Loading Dose - magnesium sulfate 6 grams IV bolus from bag Dose:** 6 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes **Admin Instructions:**
Loading Dose - Bolus from Bag

☑ **Maintenance Dose - magnesium sulfate CONTINUOUS infusion Dose:** 4 **Route:** intravenous **Frequency:** continuous

○ **magnesium sulfate 4 gm Loading and Maintenance Infusion**

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

DISCONTINUE INFUSION AND CALL PROVIDER IF SYMPTOMS OF MAGNESIUM TOXICITY ARE PRESENT.

- [x] **Monitor for signs/symptoms of Magnesium Toxicity: decreased or absent DTRs, decreased or changes in level of consciousness, decreased respiratory rate (less than 10 breaths/minute), oliguria (less than 30 mililiters/hour), shortness of breath or tightness in chest Frequency:** Until discontinued **Priority:** Routine
- [x] **magnesium sulfate 4 gm IV Loading Dose + Maintenance infusion**
  - [x] **Loading Dose - magnesium sulfate 4 grams IV bolus from bag Dose:** 4 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Minimum Infusion Duration:** 30.000 Minutes **Admin Instructions:**
    Loading Dose - Bolus from Bag
  - [x] **Maintenance Dose - magnesium sulfate CONTINUOUS infusion Dose:** 4 **Route:** intravenous **Frequency:** continuous
- ○ **Magnesium Sulfate Maintenance Only**

DISCONTINUE INFUSION AND CALL PROVIDER IF SYMPTOMS OF MAGNESIUM TOXICITY ARE PRESENT.

- [x] **Monitor for signs/symptoms of Magnesium Toxicity: decreased or absent DTRs, decreased or changes in level of consciousness, decreased respiratory rate (less than 10 breaths/minute), oliguria (less than 30 mililiters/hour), shortness of breath or tightness in chest Frequency:** Until discontinued **Priority:** Routine
- [x] **Maintenance Dose - magnesium sulfate CONTINUOUS infusion Dose:** 2 g/hr **Route:** intravenous **Frequency:** continuous

- [ ] **Corticosteroids**
  - ○ **betamethasone acetate & sodium phosphate (CELESTONE) injection Dose:** 12 mg **Route:** intramuscular **Frequency:** once **Frequency Limit:** 1 Occurrences
  - ○ **betamethasone acetate & sodium phosphate (CELESTONE) injection Dose:** 12 mg **Route:** intramuscular **Frequency:** every 12 hours **Frequency Limit:** 2 Occurrences
  - ○ **betamethasone acetate & sodium phosphate (CELESTONE) injection Dose:** 12 mg **Route:** intramuscular **Frequency:** every 24 hours **Frequency Limit:** 2 Occurrences
- [x] **Rescue Agents**
  - [x] **calcium gluconate injection Dose:** 1 g **Route:** intravenous **Frequency:** once PRN **PRN Comment:** rescue agent **Admin Instructions:**
    Administer for respirations less than 12 breaths per minute and call MD.
    Calcium GLUCONATE 1 gm = 4.65 MEQ

    Product Admin Instructions:
    Administer at 1.5 mL/minute (150 mg/minute) or less to avoid adverse effects.
- [ ] **Chemistry**
  - [ ] **OB magnesium level Frequency:** Once **Start Date:** S **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** After loading dose (MD to enter repeat order information)
  - [ ] **OB magnesium level Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** MD to enter repeat order information
  - [ ] **Comprehensive metabolic panel Frequency:** Once **Start Date:** S+1 **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
  - [ ] **Electrolyte panel Frequency:** Conditional Frequency **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Electrolyte panel after 24 hours if receiving combination of Pitocin and Magnesium Sulfate therapy

- [ ] **OB Hypertensive Crisis Panel**
- [x] **Notify**
  - [x] **Notify physician if systolic blood pressure is greater than or equal to 160 mm Hg or if diastolic blood pressure is greater than or equal to 110 mm Hg Frequency:** Until discontinued **Priority:** Routine
- [ ] **Initial First-Line Management - Select one** (Required)

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

○ **Initial First-Line Management with Labetalol**

☑ **Initial First-Line Management with Labetalol**

☑ **labetalol (TRANDATE) injection Dose:** 20 mg **Route:** intravenous **Frequency:** once PRN **PRN Comment:** for severe blood pressure elevation (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg) persisting for 15 minutes or more.
Question(s):
BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested
BP & HR HOLD for: ○ Systolic BP LESS than 100 mmHg ○ Heart Rate LESS than 50 bpm
Admin Instructions:
Dose #1 of Labetalol
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.

☑ **labetalol (TRANDATE) injection Dose:** 40 mg **Route:** intravenous **Frequency:** once PRN **Frequency Limit:** 1 Occurrences **PRN Comment:** If severe BP elevation persists 10 minutes AFTER the first dose of Labetalol (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg)
Question(s):
BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested
BP & HR HOLD for: ○ Systolic BP LESS than 100 mmHg ○ Heart Rate LESS than 50 bpm
Admin Instructions:
Dose #2 of Labetalol - If BP threshold still exceeded 10 minutes after first dose administered.
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.

☑ **labetalol (TRANDATE) injection Dose:** 80 mg **Route:** intravenous **Frequency:** once PRN **PRN Comment:** If severe BP elevation persists 10 minutes AFTER the second dose of Labetalol (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg)
Question(s):
BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested
BP & HR HOLD for: ○ Systolic BP LESS than 100 mmHg ○ Heart Rate LESS than 50 bpm
Admin Instructions:
Dose #3 of Labetalol - If BP threshold still exceeded 10 minutes after second dose administered.
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.

☑ **hydrALAZINE (APRESOLINE) injection Dose:** 10 mg **Route:** intravenous **Frequency:** once PRN **PRN Comment:** If severe BP elevation persists 10 minutes AFTER the third dose of Labetalol (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg)
Question(s):
BP HOLD parameters for this order: ○ BP Hold Parameters requested
BP HOLD for: Systolic BP LESS than 100 mmHg
Contact Physician if:
Admin Instructions:
Give 10 minutes AFTER last dose (#3) of Labetalol If BP threshold still exceeded.
Give IV Push over 2 minutes
If AFTER Hydralazine administration BP is BELOW threshold, continue to monitor BP closely

○ **Initial First-Line Management with Hydralazine**

☑ **hydrALAZINE (APRESOLINE) injection Dose:** 5 mg **Route:** intravenous **Frequency:** once PRN **PRN Comment:** for severe blood pressure elevation (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg) persisting for 15 minutes or more.
Question(s):
BP HOLD parameters for this order: ○ ONCE or PRN Orders - No Hold Parameters Needed
Contact Physician if:
Admin Instructions:
Give IV Push over 2 minutes
Repeat BP measurements in 20 minutes and record results.

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

☑ **hydrALAZINE (APRESOLINE) injection** **Dose:** 10 mg **Route:** intravenous **Frequency:** once PRN **PRN Comment:** If severe BP elevation persists 20 minutes AFTER the first dose of Hydralazine (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg)
Question(s):
BP HOLD parameters for this order: ○ ONCE or PRN Orders - No Hold Parameters Needed
Contact Physician if:
Admin Instructions:
Dose #2 of Hydralazine - If BP threshold still exceeded 20 minutes after first dose administered.
Give IV Push over 2 minutes
Repeat BP measurements in 20 minutes and record results.

☑ **labetalol (TRANDATE) injection** **Dose:** 20 mg **Route:** intravenous **Frequency:** once PRN **PRN Comment:** If severe BP elevation persists 20 minutes AFTER the second dose of Hydralazine (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg)
Question(s):
BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested
BP & HR HOLD for: ○ Systolic BP LESS than 100 mmHg ○ Heart Rate LESS than 50 bpm
Admin Instructions:
Dose #1 of Labetalol
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.

☑ **labetalol (TRANDATE) injection** **Dose:** 40 mg **Route:** intravenous **Frequency:** once PRN **Frequency Limit:** 1 Occurrences **PRN Comment:** If severe BP elevation persists 10 minutes AFTER the first dose of Labetalol (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg)
Question(s):
BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested
BP & HR HOLD for: ○ Systolic BP LESS than 100 mmHg ○ Heart Rate LESS than 50 bpm
Admin Instructions:
Dose #2 of Labetalol - If BP threshold still exceeded 10 minutes after first dose administered.
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.

○ **Initial First-Line Management with Oral Nifedipine**

☑ **NIFEdipine (PROCARDIA) capsule** **Dose:** 10 mg **Route:** oral **Frequency:** once PRN **Frequency Limit:** 1 Occurrences **PRN Comment:** for severe blood pressure elevation (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg) persisting for 15 minutes or more.
Question(s):
Nifedpine IR ordering errors have been associated with medication formulation mix-ups (Immediate Release instead of Sustained Release). Indicate that you have validated the IR formulation dose selected is as intended.:
Indication:
BP HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Dose #1 of Nifedipine
Repeat BP measurements in 20 minutes and record results.
Product Admin Instructions:
SWALLOW WHOLE. DO NOT CRUSH, SPLIT OR CHEW.

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

☑ **NIFEdipine (PROCARDIA) capsule** **Dose:** 20 mg **Route:** oral **Frequency:** once PRN **Frequency Limit:** 1 Occurrences **PRN Comment:** for severe BP elevation persists 20 minutes AFTER the first dose of Nifedipine (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg)
Question(s):
Nifedpine IR ordering errors have been associated with medication formulation mix-ups (Immediate Release instead of Sustained Release). Indicate that you have validated the IR formulation dose selected is as intended.:
Indication:
BP HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Dose #2 of Nifedipine
Repeat BP measurements in 20 minutes and record results.
If BP is BELOW threshold, continue to monitor BP closely.
Product Admin Instructions:
SWALLOW WHOLE. DO NOT CRUSH, SPLIT OR CHEW.

☑ **labetalol (TRANDATE) injection** **Dose:** 40 mg **Route:** intravenous **Frequency:** once PRN **Frequency Limit:** 1 Occurrences **PRN Comment:** If severe BP elevation persists 20 minutes AFTER the second dose of Nifedipine (systolic BP GREATER than or EQUAL to 160 mm Hg or diastolic BP GREATER than or EQUAL to 110 mm Hg)
Question(s):
BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested
BP & HR HOLD for: ○ Systolic BP LESS than 100 mmHg ○ Heart Rate LESS than 50 bpm
Admin Instructions:
Give IV Push over 2 minutes
Repeat BP measurements in 10 minutes and record results.

☐ **Pre-Eclamptic Lab Panel**

☑ **CBC with differential** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Comprehensive metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Prothrombin time with INR** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Partial thromboplastin time** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **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.

☑ **Fibrinogen** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Uric acid** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **LDH** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Urine Protein and Creatinine**

☑ **Creatinine level, urine, random** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine

☑ **Protein, urine, random** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine

☐ **Physician Consult**

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

☐ **Consult Anesthesiology** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
Question(s):
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

☐ **Consult Cardiology** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
Question(s):
Reason for Consult?
Provider Group:
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

☐ **Consult Neurology** **Frequency:** Once **Priority:** Routine
Question(s):
Provider Group:
Reason for Consult?
Reason for Consult:
Patient/Clinical information communicated?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Process Instructions:
The To Provider OR Provider Group field must be completed.

For all STROKE CODES: use the Team Activation order
Primary Ordering Comments:
Estimated Discharge Date: ***
Time in OBS:
Last known normal: ***
Focal Deficit: ***

☐ **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:

☐ **Consult Maternal and Fetal Medicine** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
Question(s):
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

☐ **Consult Neonatology** **Frequency:** Once **Frequency Limit:** 1 Occurrences **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:**_____

☐ **Consult Obstetrics and Gynecology** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine
Question(s):
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

Nursing

Activity

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

☑ **Patient may shower** **Frequency:** As needed **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Specify:
Additional modifier:

Vital Signs

☑ **Vital signs - T/P/R/BP** **Frequency:** Every 15 min **Priority:** Routine **Comments:** Complete vital signs every 15 minutes x 8, followed by every 4 hours x 24 hours, followed by every 8 hours until discharge. If patient has a hypertensive disorder diagnosed in pregnancy: blood pressure q 4 hours until discharge. If patient has a Systolic BP greater than or equal to 140 or Dystolic BP greater than or equal to 90: blood pressure q 4 hours until discharge.

Nursing care

☐ **Discontinue IV** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine **Comments:** Discontinue IV when infusion complete and patient is stable. May saline lock if patient still requires IV medications.

☐ **Breast pump to bed** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine

☑ **Bladder scan** **Frequency:** As needed **Phase of Care:** Postpartum **Priority:** Routine **Comments:** If patient remains unable to void 4 hrs post straight cath, insert Foley and Notify physician

☑ **Straight cath** **Frequency:** Conditional Frequency **Frequency Limit:** 1 Occurrences **Phase of Care:** Postpartum **Priority:** Routine **Comments:** Post bladder scan: If regional block and unable to void on bedpan, may straight cath x 1 then insert foley to Bed Side Drainage (record amount obtained from straight cath).

☑ **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

☑ **Uterine fundal massage** **Frequency:** Every 4 hours **Frequency Limit:** -1 **Start Date:** S **Phase of Care:** Postpartum **Priority:** Routine **Comments:** Postpartum for 24 hours and PRN

☐ **Infant skin to skin on mother immediately after birth unless not clinically appropriate** **Frequency:** Until discontinued **Phase of Care:** Postpartum **Priority:** Routine

☐ **Initiate breastfeeding immediately following delivery** **Frequency:** Until discontinued **Phase of Care:** Postpartum **Priority:** Routine

☐ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Side: Bilateral
Select Sleeve(s):

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

☐ **Place antiembolic stockings** **Frequency:** Until discontinued **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Side: Bilateral
Hose length: ○ Knee-high ○ Thigh-high

☑ **Request for central supply equipment : T-Pump (K-pad)** **Frequency:** Once **Start Date:** S **Priority:** Routine
Question(s):
Equipment Requested: ○ T-Pump (K-pad)
Special Instructions: ○ for patient comfort
Equipment Requested:
Equipment Requested:
Weight:
Process Instructions:
At this time Epic ordering is for equipment only. Please call Central Supply for your supply needs.
Isolation carts will be provided when the isolation order is entered. If a replacement cart is needed because of patient transfer, use the miscellaneous equipment request order.

☑ **Heating pad** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine

Perineal Care

☑ **Apply ice pack** **Frequency:** Until discontinued **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Afftected area: To perineum, for 8-12 hours after delivery then may have sitz bath at least two times daily, then as needed for patient discomfort.
Afftected area:
Waking hours only?
Nurse to schedule?
Special Instructions:

☐ **Sitz bath** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine **Comments:** Begin 8-12 hours post-delivery as needed

☑ **Patient education- Perineal instructions post delivery** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Patient/Family: ○ Patient
Education for: ○ Other (specify)
Specify: Perineal care instructions after delivery

Notify

☑ **Notify Physician for vitals:** **Frequency:** Until discontinued **Priority:** Routine **Comments:** Notify Physician for Validated Vital Signs
Question(s):
Temperature greater than: ○ 100.3 ○ 100.5
Systolic BP greater than: 160
Systolic BP less than: 90
Diastolic BP greater than: ○ 110 ○ 100
Diastolic BP less than: 50
Heart rate greater than (BPM): ○ 120 ○ 100
Heart rate less than (BPM): ○ 50 ○ 60
Respiratory rate greater than: ○ 24 ○ 25
Respiratory rate less than: ○ 10 ○ 8
SpO2 less than: ○ 95 ○ 92
Temperature less than:
MAP less than: 60.000

☑ **Notify Physician for abnormal bleeding** **Frequency:** Until discontinued **Priority:** Routine

☑ **Notify Physician for discharge order when:** **Frequency:** Until discontinued **Priority:** Routine **Comments:** Temperature is not above 100 degrees F for at least 12 hours, able to void adequately, able to verbalize discharge instructions, patient has discharge prescriptions, if indicated

☑ **Notify Physician if foley catheter is inserted** **Frequency:** Until discontinued **Priority:** Routine **Comments:** If patient has a regional block, unable to void on bedpan and a foley is inserted

Diet

☑ **Diet - Regular** **Frequency:** Diet effective now **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Diet(s): ○ Regular
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

☐ **Diet - Clear Liquid** **Frequency:** Diet effective now **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Diet(s): ○ Clear Liquids
Advance Diet as Tolerated? ○ Yes
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

IV Fluids

Medications

Vaccines

☑ **measles-mumps-rubella Vaccine** **Dose:** 10exp3.4-4.2- **Route:** subcutaneous **Frequency:** once PRN **Phase of Care:** Postpartum **PRN Reasons:** immunization
Admin Instructions:
Patient Consent if Rubella Non-Immune

Product Admin Instructions:
MIX THE 2 VIALS BEFORE ADMINISTRATION. SCAN THE VACCINE. DO NOT SCAN THE DILUENT. GIVE SUBCUTANEOUSLY ONLY!!

☑ **diphtheria-pertussis-tetanus (BOOSTRIX / ADACEL) Vaccine** **Dose:** 0.5 mL **Route:** intramuscular **Frequency:** once PRN **Phase of Care:** Postpartum **PRN Comment:** If not given during pregnancy.
Admin Instructions:
Upon patient consent and prior to discharge.

Prenatal Vitamins

☐ **prenatal multivitamin tab/cap** **Dose:** 1 each **Route:** oral **Frequency:** daily **Phase of Care:** Postpartum
Admin Instructions:
Prenatal Vitamin is available as a Tablet or Capsule

NALOXONE FOR OBGYN VAGINAL DELIVERY POST PARTUM OPIOID PAIN MEDICATIONS

☑ **naloxone (NARCAN) 0.4 mg/mL injection** **Dose:** 0.4 **Frequency:** every 2 min PRN **Phase of Care:** L&D Pre-Delivery **PRN Reasons:** respiratory depression
opioid reversal
Admin Instructions:
Repeat naloxone 0.2 mg once in 2 minutes if necessary (MAXIMUM 0.4 MG). If naloxone is needed, please call the ordering physician and/or CERT team. Monitor vital signs (pulse oximetry, P/R/BP) every 15 minutes for 3 times.

Mild Pain (Pain Score 1-3)

◉ **acetaminophen (TYLENOL) tablet** **Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Postpartum **PRN Reasons:** mild pain (score 1-3)
headaches
fever
Question(s):
Allowance for Patient Preference: ○ Nurse may administer for higher level of pain per patient request (selection)
Admin Instructions:
Monitor and record pain scores and respiratory status.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

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

○ **HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** every 4 hours PRN **Phase of Care:** Postpartum **PRN Reasons:** mild pain (score 1-3)
Question(s):
Allowance for Patient Preference: ○ Nurse may administer for higher level of pain per patient request (selection)
Admin Instructions:
Monitor and record pain scores and respiratory status.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **acetaminophen-codeine (TYLENOL #3) 300-30 mg per tablet** **Dose:** 1 tablet **Frequency:** every 6 hours PRN **Phase of Care:** Postpartum **PRN Reasons:** mild pain (score 1-3)
Question(s):
Allowance for Patient Preference: ○ Nurse may administer for higher level of pain per patient request (selection)
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:

Moderate Pain (Pain Score 4-6)

○ **HYDROcodone-acetaminophen (NORCO) 10-325 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Postpartum **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference: ○ Nurse may administer for higher level of pain per patient request (selection)

○ **acetaminophen-codeine (TYLENOL #3) 300-30 mg per tablet** **Dose:** 2 tablet **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Postpartum **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference: ○ Nurse may administer for higher level of pain per patient request (selection)
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:

Severe Pain (Pain Score 7-10)

○ **HYDROcodone-acetaminophen (NORCO) 10-325 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Postpartum **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:

○ **oxyCODONE-acetaminophen (PERCOCET) 5-325 mg per tablet** **Dose:** 2 tablet **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Postpartum **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Monitor and record pain scores and respiratory status.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule. Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **oxyCODONE (ROXICODONE) immediate release tablet** **Dose:** 5 mg **Route:** oral **Frequency:** every 4 hours PRN **Phase of Care:** Postpartum **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Monitor and record pain scores and respiratory status

Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

Adjunct Pain Medications

○ **ibuprofen (ADVIL,MOTRIN) tablet** **Dose:** 600 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Postpartum **PRN Comment:** Cramping, Laceration or Incision Pain
Question(s):
Allowance for Patient Preference:
Admin Instructions:
May be used in conjunction with acetaminophen with codeine (TYLENOL #3) tablets. May be used in conjunction with oral opioid agents for moderate pain
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

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

☐ **For patients ages GREATER than 64 OR weight LESS than 50 kg OR eGFR 30-59 mL/min - ketorolac (TORADOL) injection Dose:** 15 mg **Route:** intravenous **Frequency:** every 6 hours PRN **Phase of Care:** Postpartum **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
May be used in conjunction with oral opioid agents for moderate pain

☐ **For patients ages GREATER than 64 OR weight LESS than 50 kg OR eGFR 30-59 mL/min - ketorolac (TORADOL) injection Dose:** 30 mg **Route:** intravenous **Frequency:** every 6 hours PRN **Phase of Care:** Postpartum **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
May be used in conjunction with oral opioid agents for moderate pain

Perineal Care

☑ **benzocaine-menthol (DERMOPLAST) 20-0.5 % topical spray Dose:** 20-0.5 **Route:** Topical **Frequency:** PRN **Phase of Care:** Postpartum **PRN Reasons:** irritation
Admin Instructions:
PATIENT MAY SELF ADMINISTER. For topical use only. May be used in addition to systemic pain medications

☑ **glycerin-witch hazel 12.5-50 % topical (TUCKS) pads Dose:** 12.5-50 **Route:** Topical **Frequency:** daily PRN **Phase of Care:** Postpartum **PRN Reasons:** hemorrhoids
Admin Instructions:
Specify Site: Rectum
Product Admin Instructions:
PATIENT MAY SELF ADMINISTER

☐ **dibucaine (NUPERCAINAL) 1 % ointment Dose:** 1 **Route:** Topical **Frequency:** every 3 hours PRN **Phase of Care:** Postpartum
Admin Instructions:
Specify Site: Perineum
Product Admin Instructions:
PATIENT MAY SELF ADMINISTER

Breast Care

☑ **lanolin cream Dose:** 1 Application **Route:** Topical **Frequency:** PRN **Phase of Care:** Postpartum **PRN Comment:** nipple redness or pain
Admin Instructions:
Specify Site: Nipples
Product Admin Instructions:
PATIENT MAY SELF ADMINISTER

Bowel Care

☑ **docusate sodium (COLACE) capsule Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily PRN **Phase of Care:** Postpartum **PRN Reasons:** constipation

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

☐ **magnesium hydroxide suspension Dose:** 30 mL **Route:** oral **Frequency:** nightly PRN **Phase of Care:** Postpartum **PRN Reasons:** indigestion

☐ **bisacodyl (DULCOLAX) suppository - do not use with patient with 3rd or 4th degree lacerations Dose:** 10 mg **Route:** rectal **Frequency:** daily PRN **Phase of Care:** Postpartum **PRN Reasons:** constipation
Admin Instructions:
Do not use with patient with 3rd or 4th degree lacerations

Fever Care

☑ **acetaminophen (TYLENOL) tablet Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Postpartum **PRN Comment:** For temperature greater than 100.3 **PRN Reasons:** 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).

☐ **aspirin tablet Dose:** 325 mg **Route:** oral **Frequency:** every 4 hours PRN **Phase of Care:** Postpartum **PRN Comment:** For temperature greater than 100.4

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

oxytocin (PITOCIN) Bolus and Maintenance Infusion

☑ **oxytocin (PITOCIN) Bolus and Maintenance Infusion**

☑ **oxytocin 30 unit/500 mL bolus from bag** **Dose:** 10 Units **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** L&D Pre-Delivery **Minimum Infusion Duration:** 30.000 Minutes

☑ **oxytocin (PITOCIN) infusion** **Dose:** 5.7 Units/hr **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** L&D Pre-Delivery
Admin Instructions:
Run at 95 mL/hr for 3.5 hours.

Bleeding Medications

○ **oxytocin (PITOCIN) infusion and methylergonovine (METHERGINE)**
methylergonovine (METHERGINE) is contraindicated if BP GREATER than 140/90 mmHg

☑ **oxytocin (PITOCIN) infusion** **Dose:** 5.7 Units/hr **Route:** intravenous **Frequency:** continuous PRN **Phase of Care:** Postpartum **PRN Comment:** PostPartum Vaginal Bleeding
Admin Instructions:
If uterine atony or if excessive bleeding persists, infuse oxytocin at 999mL/hr.

☑ **methylergonovine (METHERGINE) injection - Contraindicated if BP GREATER than 140/90 mmHg** **Dose:** 200 mcg **Route:** intramuscular **Frequency:** once PRN **Phase of Care:** Postpartum **PRN Comment:** as needed for vaginal bleeding not controlled by oxytocin
Admin Instructions:
Use if inadequate response to oxytocin. Notify Physician if further treatment needed. Contraindicated if BP GREATER than 140/90 mmHg

○ **oxytocin (PITOCIN) infusion AND carboprost (HEMABATE) injection And diphenoxylate-atropine (LOMOTIL) oral dose**

☑ **oxytocin (PITOCIN) infusion** **Dose:** 5.7 Units/hr **Route:** intravenous **Frequency:** continuous PRN **Phase of Care:** Postpartum **PRN Comment:** PostPartum Vaginal Bleeding
Admin Instructions:
If uterine atony or if excessive bleeding persists, infuse oxytocin at 999mL/hr.

☑ **carboprost (HEMABATE) injection** **Dose:** 250 mcg **Route:** intramuscular **Frequency:** once PRN **Phase of Care:** Postpartum **PRN Comment:** for Vaginal Bleeding uncontrolled by oxytocin.
Product Admin Instructions:
Inject deeply into a large muscle such as the deltoid. Aspirate prior to injection to avoid injecting into a blood vessel.

☑ **diphenoxylate-atropine (LOMOTIL) 2.5-0.025 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** once PRN **Phase of Care:** Postpartum **PRN Reasons:** diarrhea

○ **oxytocin (PITOCIN) infusion and misoprostol (CYTOTEC)**

☑ **oxytocin (PITOCIN) infusion** **Dose:** 5.7 Units/hr **Route:** intravenous **Frequency:** continuous PRN **Phase of Care:** Postpartum **PRN Comment:** Postpartum Bleeding
Admin Instructions:
If uterine atony or if excessive bleeding persists, infuse oxytocin at 999mL/hr

☑ **misoprostol (CYTOTEC) tablet** **Dose:** 1000 mcg **Route:** oral **Frequency:** once PRN **Phase of Care:** Postpartum **PRN Comment:** as needed for vaginal bleeding not controlled by oxytocin
Admin Instructions:
Use if inadequate response to oxytocin. Notify Physician if further treatment needed.
Product Admin Instructions:
This drug presents a potential hazard to men and women actively trying to conceive or women who are pregnant or may become pregnant and are breast feeding.

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.

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

◉ **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.

Insomnia: Diphenhydramine

☑ **diphenhydrAMINE (BENADRYL) tablet Dose:** 25 mg **Route:** oral **Frequency:** nightly PRN **PRN Reasons:** sleep

Indigestion/Heartburn

☑ **famotidine (PEPCID) tablet Dose:** 20 mg **Route:** oral **Frequency:** 2 times daily PRN **PRN Reasons:** indigestion
Question(s):
Indication(s) for H2 Receptor Antagonist (H2RA) Therapy: ○ GERD

☑ **calcium carbonate (TUMS) chewable tablet Dose:** 500 mg of Calcium Carbonate **Frequency:** 3 times daily PRN **PRN Reasons:** heartburn
Admin Instructions:
Note: 500 mg calcium carbonate = 200 mg elemental calcium

Rh Negative Mother

Nursing

☑ **Rhogam Workup: If cord blood is Rh positive, complete Rhogam workup on mother and administer Rh immune globulin 300 mcg (or dose determined by lab antibody results) IM within 72 hours of delivery. Frequency:** Until discontinued **Phase of Care:** Postpartum **Priority:** Routine

Labs

☑ **Fetal Screen Frequency:** Conditional Frequency **Frequency Limit:** 1 Occurrences **Start Date:** S **End Date:** S+4 **Phase of Care:** Postpartum **Priority:** Routine **Specimen Type:** Blood **Comments:** Conditional- One activation- If Rh Negative Mom and Rh Positive infant

☐ **Rhogam Type and Screen Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine **Specimen Type:** Blood

Medication

☑ **rho(D) immune globulin (HYPERRHO/RHOGAM) injection Dose:** 1500 unit **Frequency:** PRN **Frequency Limit:** 1 Occurrences **Phase of Care:** Postpartum **PRN Comment:** Rhogam Workup: If cord blood is Rh positive, complete Rhogam workup on mother and administer Rh immune globulin 300 mcg (or dose determined by lab antibody results) IM within 72 hours of delivery.

VTE

VTE Risk and Prophylaxis Tool (Required)
VTE/DVT Risk Definitions (\\epic-nas.et0922.epichosted.com\static\OrderSets\VTE Risk Assessment Tool v7_MAK FINAL.pdf)

○ **VERY LOW Risk of VTE** (Required)

☑ **Ambulate Frequency:** 3 times daily **Phase of Care:** Postpartum **Priority:** Routine **Comments:** Early ambulation
Question(s):
Specify:

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

- [x] **Very low risk of VTE** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine
- [x] **Avoid dehydration** **Frequency:** Until discontinued **Phase of Care:** Postpartum **Priority:** Routine

○ **LOW Risk of VTE** (Required)

Delivery BMI ≥ 40 kg/m^2

- [x] **Low risk of VTE** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine

Question(s):
Low risk: Due to low risk, SCDs are recommended while in bed and until fully ambulatory
Low risk: Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

- [x] **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 of VTE** (Required)

Mechanical prophylaxis prior to delivery and until fully ambulatory. CONSIDER prophylactic LMWH/UFH throughout postpartum hospitalization.
Delivery BMI > 40 kg AND antepartum and/or intrapartum hospitalization ≥ 72 hours
Hospitalization within the last month ≥ 72 hours
Low risk thrombophilia
*BMI >40kg/m^2 AND low risk thrombophilia: consider prophylaxis continuation 6 weeks postpartum.

- [x] **Moderate Risk** (Required)
  - [x] **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine
  - [ ] **HM RX DVT OBGYN MEDIUM RISK OR HIGH-RISK PROPHYLAXIS**
    - ○ **enoxaparin (LOVENOX) injection**
      - ○ **enoxaparin (LOVENOX) injection** **Dose:** 40 mg **Route:** subcutaneous **Frequency:** daily at 1700

      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.

      - ○ **CrCl LESS than 30 mL/min - enoxaparin (LOVENOX) injection** **Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700

      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.

      - ○ **BMI GREATER THAN 40 kg/m2 - enoxaparin (LOVENOX) injection** **Dose:** 40 mg **Route:** subcutaneous **Frequency:** every 12 hours scheduled

      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.

    - ○ **Third Trimester - HEParin subcutaneous**
      - [x] **HEParin (porcine) injection** **Dose:** 10000 Units **Route:** subcutaneous **Frequency:** every 12 hours scheduled **Phase of Care:** L&D Pre-Delivery

☑ **Partial thromboplastin time, activated** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** L&D Pre-Delivery **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Obtain prior to heparin dose
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.

○ **Contact OBGYN provider after removal of epidural catheter for anticoagulation orders** **Frequency:** Until discontinued **Priority:** Routine

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

☑ **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 - Prophylaxis** (Required)
Mechanical prophylaxis prior to delivery AND until fully ambulatory PLUS prophylaxis LMWH/UFH through postpartum hospitalization & continued 6 weeks from delivery date.
High risk thrombophilia with no prior VTE
Prior idiopathic or estrogen related VTE
Low risk thrombophilia AND (family history of VTE OR single prior VTE)
Receiving outpatient prophylactic LMWH or UFH

☑ **High Risk** (Required)

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

☑ **HM RX DVT OBGYN MEDIUM RISK OR HIGH-RISK PROPHYLAXIS**

○ **enoxaparin (LOVENOX) injection**

○ **enoxaparin (LOVENOX) injection** **Dose:** 40 mg **Route:** subcutaneous **Frequency:** daily at 1700
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.

○ **CrCl LESS than 30 mL/min - enoxaparin (LOVENOX) injection** **Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
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.

○ **BMI GREATER THAN 40 kg/m2 - enoxaparin (LOVENOX) injection** **Dose:** 40 mg **Route:** subcutaneous **Frequency:** every 12 hours scheduled
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.

○ **Third Trimester - HEParin subcutaneous**

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

☑ **HEParin (porcine) injection Dose:** 10000 Units **Route:** subcutaneous **Frequency:** every 12 hours scheduled **Phase of Care:** L&D Pre-Delivery

☑ **Partial thromboplastin time, activated Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** L&D Pre-Delivery **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Obtain prior to heparin dose
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.

○ **Contact OBGYN provider after removal of epidural catheter for anticoagulation orders Frequency:** Until discontinued **Priority:** Routine

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

☑ **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 - Therapeutic** (Required)

Mechanical prophylaxis prior to delivery and until fully ambulatory PLUS therapeutic dose LMWH/UFH through hospitalization & continued 6 weeks from delivery date.
Patients already receiving outpatient therapeutic LMWH or UFH
Multiple prior VTEs
High risk thrombophilia AND prior VTE

☑ **High Risk** (Required)

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

☑ **High Risk - Therapeutic**

○ **enoxaparin (LOVENOX) injection**

☑ **enoxaparin (LOVENOX) injection Dose:** 1 mg/kg **Route:** subcutaneous **Frequency:** every 12 hours scheduled
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.

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

☐ **Anti Xa, low molecular weight heparin Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Heparin Name:
Primary Ordering Comments:
Draw specimen 4 hours after subcutaneous injection

○ **CrCl LESS THAN 30 mL/min - enoxaparin (LOVENOX) injection**

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

☑ **enoxaparin (LOVENOX) injection Dose:** 1 mg/kg **Route:** subcutaneous **Frequency:** every 24 hours scheduled
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.

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

☐ **Anti Xa, low molecular weight heparin Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Heparin Name:
Primary Ordering Comments:
Draw specimen 4 hours after subcutaneous injection

○ **Pharmacy Consult to Manage Heparin: STANDARD dose protocol (DVT/PE) Frequency:** Until discontinued **Priority:** Routine **Comments:** For initiation 12 hours post-delivery. Ensure epidural removed and adequate time after removal prior to therapy initiation.
Question(s):
Heparin Indication:
Specify:
Specify:
Monitoring:
Process Instructions:
Standard Dose Protocol

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

See protocol for details

○ **Contact OBGYN provider after removal of epidural catheter for anticoagulation orders Frequency:** Until discontinued **Priority:** Routine

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

☑ **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):

○ **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**

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):

○ **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):

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

VTE Risk and Prophylaxis Tool

VTE/DVT Risk Definitions (\\epic-nas.et0922.epichosted.com\static\OrderSets\VTE Risk Assessment Tool v7_MAK FINAL.pdf)

○ **VERY LOW Risk of VTE** (Required)

☑ **Ambulate** **Frequency:** 3 times daily **Phase of Care:** Postpartum **Priority:** Routine **Comments:** Early ambulation
Question(s):
Specify:

☑ **Very low risk of VTE** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine

☑ **Avoid dehydration** **Frequency:** Until discontinued **Phase of Care:** Postpartum **Priority:** Routine

○ **LOW Risk of VTE** (Required)

Delivery BMI ≥ 40 kg/m^2

☑ **Low risk of VTE** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Low risk: Due to low risk, SCDs are recommended while in bed and until fully ambulatory
Low risk: Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

☑ **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 of VTE** (Required)

Mechanical prophylaxis prior to delivery and until fully ambulatory. CONSIDER prophylactic LMWH/UFH throughout postpartum hospitalization.
Delivery BMI > 40 kg AND antepartum and/or intrapartum hospitalization ≥ 72 hours
Hospitalization within the last month ≥ 72 hours
Low risk thrombophilia
*BMI >40kg/m^2 AND low risk thrombophilia: consider prophylaxis continuation 6 weeks postpartum.

☑ **Moderate Risk** (Required)

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

☐ **HM RX DVT OBGYN MEDIUM RISK OR HIGH-RISK PROPHYLAXIS**

○ **enoxaparin (LOVENOX) injection**

○ **enoxaparin (LOVENOX) injection** **Dose:** 40 mg **Route:** subcutaneous **Frequency:** daily at 1700
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.

○ **CrCl LESS than 30 mL/min - enoxaparin (LOVENOX) injection** **Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
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.

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

○ **BMI GREATER THAN 40 kg/m2 - enoxaparin (LOVENOX) injection Dose:** 40 mg **Route:** subcutaneous **Frequency:** every 12 hours scheduled
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.

○ **Third Trimester - HEParin subcutaneous**

☑ **HEParin (porcine) injection Dose:** 10000 Units **Route:** subcutaneous **Frequency:** every 12 hours scheduled **Phase of Care:** L&D Pre-Delivery

☑ **Partial thromboplastin time, activated Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** L&D Pre-Delivery **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Obtain prior to heparin dose
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.

○ **Contact OBGYN provider after removal of epidural catheter for anticoagulation orders Frequency:** Until discontinued **Priority:** Routine

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

☑ **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 - Prophylaxis** (Required)
Mechanical prophylaxis prior to delivery AND until fully ambulatory PLUS prophylaxis LMWH/UFH through postpartum hospitalization & continued 6 weeks from delivery date.
High risk thrombophilia with no prior VTE
Prior idiopathic or estrogen related VTE
Low risk thrombophilia AND (family history of VTE OR single prior VTE)
Receiving outpatient prophylactic LMWH or UFH

☑ **High Risk** (Required)

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

☑ **HM RX DVT OBGYN MEDIUM RISK OR HIGH-RISK PROPHYLAXIS**

○ **enoxaparin (LOVENOX) injection**

○ **enoxaparin (LOVENOX) injection Dose:** 40 mg **Route:** subcutaneous **Frequency:** daily at 1700
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.

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

○ **CrCl LESS than 30 mL/min - enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
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.

○ **BMI GREATER THAN 40 kg/m2 - enoxaparin (LOVENOX) injection Dose:** 40 mg **Route:** subcutaneous **Frequency:** every 12 hours scheduled
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.

○ **Third Trimester - HEParin subcutaneous**

☑ **HEParin (porcine) injection Dose:** 10000 Units **Route:** subcutaneous **Frequency:** every 12 hours scheduled **Phase of Care:** L&D Pre-Delivery

☑ **Partial thromboplastin time, activated Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** L&D Pre-Delivery **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** Obtain prior to heparin dose
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.

○ **Contact OBGYN provider after removal of epidural catheter for anticoagulation orders Frequency:** Until discontinued **Priority:** Routine

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

☑ **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 - Therapeutic** (Required)
Mechanical prophylaxis prior to delivery and until fully ambulatory PLUS therapeutic dose LMWH/UFH through hospitalization & continued 6 weeks from delivery date.
Patients already receiving outpatient therapeutic LMWH or UFH
Multiple prior VTEs
High risk thrombophilia AND prior VTE

☑ **High Risk** (Required)

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

☑ **High Risk - Therapeutic**

○ **enoxaparin (LOVENOX) injection**

☑ **enoxaparin (LOVENOX) injection Dose:** 1 mg/kg **Route:** subcutaneous **Frequency:** every 12 hours scheduled
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.

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

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

☐ **Anti Xa, low molecular weight heparin** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Heparin Name:
Primary Ordering Comments:
Draw specimen 4 hours after subcutaneous injection

○ **CrCl LESS THAN 30 mL/min - enoxaparin (LOVENOX) injection**

☑ **enoxaparin (LOVENOX) injection** **Dose:** 1 mg/kg **Route:** subcutaneous **Frequency:** every 24 hours scheduled
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.

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

☐ **Anti Xa, low molecular weight heparin** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Heparin Name:
Primary Ordering Comments:
Draw specimen 4 hours after subcutaneous injection

○ **Pharmacy Consult to Manage Heparin: STANDARD dose protocol (DVT/PE)** **Frequency:** Until discontinued **Priority:** Routine **Comments:** For initiation 12 hours post-delivery. Ensure epidural removed and adequate time after removal prior to therapy initiation.
Question(s):
Heparin Indication:
Specify:
Specify:
Monitoring:
Process Instructions:
Standard Dose Protocol

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

See protocol for details

○ **Contact OBGYN provider after removal of epidural catheter for anticoagulation orders** **Frequency:** Until discontinued **Priority:** Routine

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

☑ **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):

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

Labs

Hematology

☐ **CBC with platelet and differential** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Postpartum **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hemoglobin** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Postpartum **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hematocrit** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Postpartum **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Comprehensive metabolic panel** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Postpartum **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Basic metabolic panel** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Postpartum **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Chemistry

☐ **Creatinine** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Start Date:** S+1 **Phase of Care:** Postpartum **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Hypertensive Lab Panel

☐ **Pre-Eclamptic Lab Panel**

☑ **CBC with differential** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Comprehensive metabolic panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Prothrombin time with INR** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Partial thromboplastin time** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **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.

☑ **Fibrinogen** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Uric acid** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **LDH** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Urine Protein and Creatinine**

☑ **Creatinine level, urine, random** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine

☑ **Protein, urine, random** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine

Cardiology

Imaging

Other Studies

Respiratory

Rehab

Consults

For Physician Consult orders use sidebar

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

Ancillary Consults

☐ **Consult to Case Management** **Frequency:** Once **Phase of Care:** Postpartum **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 Lactation Consultant** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Reason for Lactation Consult: ○ Newborn evaluation and education
Reason for Consult?

☐ **Consult PT/OT for Pelvic Floor Therapy OB**

☑ **Consult to PT for pelvic floor therapy OB** **Frequency:** Once **Priority:** Routine
Question(s):
Reasons for referral to Physical Therapy (mark all applicable):
Are there any restrictions for positioning or mobility?
Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):
Weight Bearing Status:
Reason for PT?
Process Instructions:
If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting physical therapy

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

☑ **Consult to OT for pelvic floor therapy OB** **Frequency:** Once **Priority:** Routine
Question(s):
Reason for referral to Occupational Therapy (mark all that apply):
Are there any restrictions for positioning or mobility?
Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):
Weight Bearing Status:
Reason for OT?
Process Instructions:
If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting occupational therapy

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

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

☐ **Consult to Spiritual Care** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Reason for consult?
Reason for Consult?
Process Instructions:
For requests after hours, call the house operator.

☐ **Consult to PT eval and treat** **Frequency:** Once **Phase of Care:** Postpartum **Priority:** Routine
Question(s):
Reasons for referral to Physical Therapy (mark all applicable):
Are there any restrictions for positioning or mobility?
Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):
Weight Bearing Status:
Reason for PT?
Process Instructions:
If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting physical therapy

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

Additional Orders

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