Skin and Wound Care (1717)

Version: 6 **Gen:** 10/26/2026

Location: _____

General

Nursing

Activity/Pressure Relief

☐ **Ambulate with assistance** **Frequency:** 3 times daily **Priority:** Routine
Question(s):
Specify: ○ with assistance

☐ **Elevate extremity** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Additional instructions: ○ elevate extremity
Position:

☐ **Activity - Up with assistance** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Specify: ○ Up with assistance

☐ **Activity - Up in chair** **Frequency:** Until discontinued **Priority:** Routine **Comments:** As tolerated.
Question(s):
Specify: ○ Up in chair

☐ **Positioning instruction** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Position:
Additional instructions:

☐ **Turn patient** **Frequency:** Every 2 hours **Priority:** Routine

☐ **Weight bearing** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Weight Bearing Status:
Extremity:

Nursing Care

☐ **Intake and output** **Frequency:** Every shift **Priority:** Routine

☐ **Measure drainage** **Frequency:** Once **Priority:** Routine
Question(s):
Type of drain:

☐ **Ostomy management** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Colostomy irrigation (mLs):

☐ **Wound Care Orders + Medication**

☑ **Wound care orders** **Frequency:** Every 12 hours **Priority:** Routine
Question(s):
Location:
Site:
Irrigate wound?
Apply:
Dressing Type:
Process Instructions:
This Nursing Order is NOT for a CONSULT for PT Wound Care or WOC nurse. The order is not transmitted to any department.

Do NOT use this order to request :
Bedside debridement, Ultrasound Therapy, Pulsed Lavage, Negative Pressure Vacuum Therapy, Compression therapy, WOC ongoing wound /ostomy management and teaching.

☑ **wound care medications**
Please select the appropriate medication for wound care

☐ **mupirocin (BACTROBAN) 2 % ointment** **Dose:** 2 **Frequency:** 3 times daily
Admin Instructions:
Specify Site: ***

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

☐ **collagenase (SANTYL) ointment Dose:** 250 **Frequency:** daily
Admin Instructions:
Location to be applied: ***

☐ **silver sulfadiazine (SILVADENE, SSD) 1 % cream Dose:** 1 **Frequency:** daily
Admin Instructions:
Specify Site: ***

☐ **zinc oxide 20 % ointment Dose:** 20
Admin Instructions:
Specify Site: ***

☐ **white petrolatum-mineral oil (EUCERIN) topical cream Frequency:** PRN
Admin Instructions:
Specify Site: ***

☐ **silver gel Dose:** 32

☐ **gel dressing gel**
Admin Instructions:
Specify Site: ***

☐ **sodium hypochlorite (DAKIN'S (QUARTER-STRENGTH)) 0.125 % external solution Dose:** 0.125 **Frequency:** once

☐ **sodium hypochlorite (DAKIN'S (HALF-STRENGTH)) 0.25 % external solution Dose:** 0.25 **Frequency:** once

☐ **sodium hypochlorite (DAKIN'S) 0.5 % external solution Dose:** 0.5 **Frequency:** once

☐ **Drain care Frequency:** Until discontinued **Priority:** Routine
Question(s):
Drain 1:
Drain 2:
Drain 3:
Drain 4:
All Drains:

☐ **Patient may shower with wound covered Frequency:** Daily **Priority:** Routine
Question(s):
Specify: ○ with wound covered
Additional modifier:

☐ **Patient may shower with wound open Frequency:** Daily **Priority:** Routine
Question(s):
Specify: ○ with wound open
Additional modifier:

☐ **Negative pressure wound therapy (Not a consult order) Frequency:** Every Mon, Wed, Fri **Priority:** Routine
Question(s):
Pressure (mmHg): 125
Existing wound vac?
Type of Wound:
Wound Location:
Therapy Settings:
Intensity:
Foam Type:

☐ **chlorhexidine (HIBICLENS) 4 % liquid Dose:** 4 **Route:** Topical **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Specify Site: ***

☐ **povidone-iodine (BETADINE) 10 % external solution Dose:** 10 **Route:** Topical **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Specify Site: ***

Nursing Care

☐ **Intake and output Frequency:** Every shift **Priority:** Routine

☐ **Measure drainage Frequency:** Once **Priority:** Routine
Question(s):
Type of drain:

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

☐ **Ostomy management** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Colostomy irrigation (mLs):

☐ **Wound Care Orders + Medication**

☑ **Wound care orders** **Frequency:** Every 12 hours **Priority:** Routine
Question(s):
Location:
Site:
Irrigate wound?
Apply:
Dressing Type:
Process Instructions:
This Nursing Order is NOT for a CONSULT for PT Wound Care or WOC nurse. The order is not transmitted to any department.

Do NOT use this order to request :
Bedside debridement, Ultrasound Therapy, Pulsed Lavage, Negative Pressure Vacuum Therapy, Compression therapy, WOC ongoing wound /ostomy management and teaching.

☑ **wound care medications**
Please select the appropriate medication for wound care

☐ **mupirocin (BACTROBAN) 2 % ointment** **Dose:** 2 **Frequency:** 3 times daily
Admin Instructions:
Specify Site: ***

☐ **collagenase (SANTYL) ointment** **Dose:** 250 **Frequency:** daily
Admin Instructions:
Location to be applied: ***

☐ **silver sulfadiazine (SILVADENE, SSD) 1 % cream** **Dose:** 1 **Frequency:** daily
Admin Instructions:
Specify Site: ***

☐ **zinc oxide 20 % ointment** **Dose:** 20
Admin Instructions:
Specify Site: ***

☐ **white petrolatum-mineral oil (EUCERIN) topical cream** **Frequency:** PRN
Admin Instructions:
Specify Site: ***

☐ **silver gel** **Dose:** 32

☐ **gel dressing gel**
Admin Instructions:
Specify Site: ***

☐ **sodium hypochlorite (DAKIN'S (QUARTER-STRENGTH)) 0.125 % external solution** **Dose:** 0.125 **Frequency:** once

☐ **sodium hypochlorite (DAKIN'S (HALF-STRENGTH)) 0.25 % external solution** **Dose:** 0.25 **Frequency:** once

☐ **sodium hypochlorite (DAKIN'S) 0.5 % external solution** **Dose:** 0.5 **Frequency:** once

☐ **Patient may shower with wound covered** **Frequency:** Daily **Priority:** Routine
Question(s):
Specify: ○ with wound covered
Additional modifier:

☐ **Patient may shower with wound open** **Frequency:** Daily **Priority:** Routine
Question(s):
Specify: ○ with wound open
Additional modifier:

☐ **chlorhexidine (HIBICLENS) 4 % liquid** **Dose:** 4 **Route:** Topical **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Specify Site: ***

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

☐ **povidone-iodine (BETADINE) 10 % external solution** **Dose:** 10 **Route:** Topical **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Specify Site: ***

Equipment

Support Surface Resource Guides
(http://www.tmh.tmc.edu/tmh/methodistnursing/nursing/Pressure%20Ulcer%20Site.htm)

☐ **Supplies / kit to bedside** **Frequency:** Once **Priority:** Routine

☐ **Roho Mattress** **Frequency:** Once **Priority:** Routine
Question(s):
Clinical Indications. Criteria 1, or Criteria 2 or 3 and at least one of 4-7:
Special Instructions:
Weight:

☐ **KinAir bed with scales** **Frequency:** Once **Priority:** Routine
Question(s):
Clinical Indication(s): Group II Must select as indicated - Criteria 1 and 2 and 3 or, - Criteria 4, or Criteria 5 and 6:
Special Instructions:
Weight:

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:

☐ **Oral supplements** **Priority:** Routine
Question(s):
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:

IV Fluids

Medications

Tetanus Immunization Orders

○ **For patients 2 months to 6 years old - DTaP (INFANRIX) injection** **Dose:** 0.5 mL **Route:** intramuscular **Frequency:** once **Frequency Limit:** 1 Occurrences

○ **For patients 7 years old or older - tetanus-diphtheria toxoids-Td (TENIVAC) injection** **Dose:** 0.5 mL **Route:** intramuscular **Frequency:** once **Frequency Limit:** 1 Occurrences

○ **For patients 11 years old or older - Tdap (ADACEL) injection** **Dose:** 0.5 mL **Route:** intramuscular **Frequency:** once **Frequency Limit:** 1 Occurrences

Medications Prior to Dressing Changes

☐ **Pain Medications**

○ **HYDROmorphone (DILAUDID) injection** **Dose:** 0.1 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Comment:** Prior to dressing changes
Admin Instructions:
Monitor and record pain scores and respiratory status

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

○ **morPHINE injection Dose:** 2 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Comment:** Prior to dressing changes
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Monitor and record pain scores and respiratory status

○ **fentaNYL (SUBLIMAZE) injection Dose:** 25 mcg **Frequency:** every 8 hours PRN **PRN Comment:** Prior to dressing changes
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Monitor and record pain scores and respiratory status

☐ **lidocaine-epi-tetracaine (LET) topical solution Dose:** 4 %-1:1000 **Route:** Topical **Frequency:** once
Admin Instructions:
Specify Site: ***

☐ **lidocaine HCL (URO-JET) 2 % jelly Dose:** 2 **Route:** Topical **Frequency:** once

☐ **lidocaine (XYLOCAINE) 1 % injection Dose:** 10 **Route:** infiltration **Frequency:** once
Admin Instructions:
Infiltrate around wound prior to dressing changes.

☐ **lidocaine-EPINEPHrine (XYLOCAINE W/EPI) 1 %-1:100,000 injection Route:** infiltration
Admin Instructions:
Infiltrate around wound prior to dressing changes.

☐ **lidocaine (XYLOCAINE) 2 % injection Dose:** 20 **Route:** infiltration
Admin Instructions:
Infiltrate around wound prior to dressing changes.

☐ **lidocaine-EPINEPHrine (XYLOCAINE W/EPI) 2 %-1:100,000 injection Route:** infiltration
Admin Instructions:
Infiltrate around wound prior to dressing changes.

☐ **bupivacaine (MARCAINE) 0.25 % injection Dose:** 0.25 **Route:** infiltration **Frequency:** once
Admin Instructions:
Infiltrate around wound prior to dressing changes.

☐ **bupivacaine-EPINEPHrine (MARCAINE w/EPI) 0.25 %-1:200,000 injection Route:** infiltration
Admin Instructions:
Infiltrate around wound prior to dressing changes.

☐ **bupivacaine (MARCAINE) 0.5 % injection Dose:** 0.5 **Route:** infiltration
Admin Instructions:
Infiltrate around wound prior to dressing changes.

☐ **bupivacaine-EPINEPHrine (MARCAINE w/EPI) 0.5 %-1:200,000 injection Route:** infiltration
Admin Instructions:
Infiltrate around wound prior to dressing changes.

Medications

☐ **heparin (porcine) injection Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 12 hours scheduled

☐ **neomycin-bacitracnZn-polymyxnB (NEOSPORIN) triple antibiotic ointment Dose:** 3.5mg-400 unit- **Route:** Topical **Frequency:** 3 times daily
Admin Instructions:
Apply to affected area.

☐ **collagenase (SANTYL) ointment Dose:** 250 **Route:** Topical **Frequency:** daily
Admin Instructions:
Apply a nickel-thickness layer of collagenase (SANTYL) ointment to the wound bed. Cover with a Mepilex. Change daily.

☐ **mupirocin (BACTROBAN) 2 % ointment Dose:** 2 **Route:** Topical **Frequency:** 3 times daily
Admin Instructions:
Specify Site: ***

☐ **silver sulfadiazine (SILVADENE) 1 % cream Dose:** 1 **Route:** Topical **Frequency:** daily
Admin Instructions:
Specify Site: ***

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

- [ ] **white petrolatum 42 % ointment** **Dose:** 42 **Route:** Topical **Frequency:** PRN
Admin Instructions:
Specify Site: ***

- [ ] **sodium hypochlorite 0.125% (DAKIN'S (QUARTER-STRENGTH)) external solution** **Dose:** 0.125 **Route:** irrigation **Frequency:** once

- [ ] **sodium hypochlorite 0.25% (DAKIN'S (HALF-STRENGTH)) external solution** **Dose:** 0.25 **Route:** irrigation **Frequency:** once

- [ ] **sodium hypochlorite 0.5% (DAKIN'S FULL-STRENGTH) external solution** **Dose:** 0.5 **Route:** irrigation **Frequency:** once

- [ ] **multivitamin (THERAGRAN) per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** daily

- [ ] **therapeutic multivitamin liquid** **Dose:** 15 mL **Route:** oral **Frequency:** daily

- [ ] **zinc sulfate tablet** **Dose:** 220 mg **Route:** oral **Frequency:** daily

- [ ] **ascorbic acid (VITAMIN C) tablet** **Dose:** 500 mg **Route:** oral **Frequency:** daily

- [ ] **vitamin A capsule** **Dose:** 20000 Units **Route:** oral **Frequency:** daily **Frequency Limit:** 10 Days
Product Admin Instructions:
Please note: 10,000 units = 3,000 mcg

VTE

Labs

Labs

To improve glycemic control in hospitalized patients:
Obtain a HbA1c if patient IS a known diabetic and has not had a HbA1c in the past 3 months or if recent HbA1c result is unknown.
Obtain a HbA1c if patient IS NOT a known diabetic and initial glucose is 180 or greater

- [ ] **CBC with platelet and differential** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

- [ ] **Prealbumin** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

- [ ] **Partial thromboplastin time** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Do not draw blood from the arm that has heparin infusion. Do not draw from heparin flushed lines. If there is no other access other than the heparin line, then stop the heparin, flush the line, and aspirate 20 ml of blood to waste prior to drawing a specimen.

- [ ] **Basic metabolic panel** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

- [ ] **Comprehensive metabolic panel** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

- [ ] **C-reactive protein** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

- [ ] **Hemoglobin A1c** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

- [ ] **Sedimentation rate** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

- [ ] **Blood culture, aerobic and anaerobic x 2**

  - [x] **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)

    - [x] **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.

    - [x] **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.

Wound Cultures

- [ ] **Aerobic culture** **Frequency:** Once **Priority:** Routine

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

- [ ] **Anaerobic culture** **Frequency:** Once **Priority:** Routine
- [ ] **AFB culture** **Frequency:** Once **Priority:** Routine
- [ ] **AFB stain** **Frequency:** Once **Priority:** Routine **Specimen Type:** Sputum
- [ ] **Fungus culture** **Frequency:** Once **Priority:** Routine
- [ ] **Tissue culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Tissue
- [ ] **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**
  - [x] **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**
    - [x] **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares
  - [x] **MRSA PCR has been ordered within 24 hours. Repeat testing is not indicated at this time.**
    @LASTLAB(MRSAPCR)@
    - [ ] **MRSA PCR has been ordered within 24 hours. Repeat testing is not indicated at this time.** **Frequency:** Until discontinued **Priority:** Routine
  - [x] **MRSA PCR has been ordered within the last 7 days. This test has shown to retain high negative predictive value within this time interval.**
    @LASTLAB(MRSAPCR)@
    - [ ] **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares
  - [x] **This patient has a positive MRSA PCR result within the last 7 days.**
    @LASTLAB(MRSAPCR)@
    - [ ] **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares
  - [x] **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**
    @LASTLAB(MRSAPCR)@
    - [x] **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares
- [ ] **VRE culture** **Frequency:** Once **Priority:** Routine **Specimen Type:** Stool

Cardiology

Imaging

Other Studies

Respiratory

Rehab

Consults

For Physician Consult orders use sidebar

Ancillary Consults

- [ ] **Consult to Wound Ostomy Care nurse** **Frequency:** Once **Priority:** Routine

Question(s):
Reason for consult:
Reason for consult:
Reason for consult:
Reason for consult:
Consult for NPWT:
Reason for consult:
Reason for consult:
Reason for Consult?

Process Instructions:
This is NOT for PT Wound Care Consult order.

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

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

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

☐ **Consult to PT Wound Care Eval and Treat** **Frequency:** Once **Priority:** Routine
Question(s):
Special Instructions:
Location of Wound?
Reason for PT?

☐ **Consult OT eval and treat** **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 Nutrition Services** **Frequency:** Once **Priority:** Routine
Question(s):
Reason For Consult?
Purpose/Topic:
Reason for Consult?

☐ **Consult to Case Management** **Frequency:** Once **Priority:** Routine
Question(s):
Consult Reason:
Reason for Consult?
Process Instructions:
If Ordering IV antimicrobial therapy, an additional consult to Case Management OPAT order is needed.

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

Physician Consult

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

☐ **Consult Cardiovascular Surgery** **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:_____

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

☐ **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:

☐ **Consult Orthopedic Surgery** **Frequency:** Once **Priority:** Routine
Question(s):
Have you called the Ortho pager: 713-606-7751?
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:
Process Instructions:
For In-House referrals or ED consults, please ensure that you have appropriate X-ray imaging and page the on call resident at 713-606-7751. The on call Attending can be found on the HMH call schedule on QGenda. Chart consults placed without discussing the case with the on call resident will cause a significant delay in care.

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

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

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

Physician Consult

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

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

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

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

☐ **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:

☐ **Consult Orthopedic Surgery** **Frequency:** Once **Priority:** Routine
Question(s):
Have you called the Ortho pager: 713-606-7751?
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:
Process Instructions:
For In-House referrals or ED consults, please ensure that you have appropriate X-ray imaging and page the on call resident at 713-606-7751. The on call Attending can be found on the HMH call schedule on QGenda. Chart consults placed without discussing the case with the on call resident will cause a significant delay in care.

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

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

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

Additional Orders

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