Thoracic Surgery Post-Op (1886)

Version: 9 **Gen:** 10/26/2026

Location: _____

General

Common Present on Admission Diagnosis

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

Elective Outpatient, Observation, or Admission

- ○ **Elective outpatient procedure: Discharge following routine recovery** **Frequency:** Continuous **Phase of Care:** PACU & Post-op **Priority:** Routine
- ○ **Outpatient observation services under general supervision** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine

Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

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

○ **Outpatient in a bed - extended recovery** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

○ **Admit to Inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Level of Care:
Patient Condition:
Bed request comments:
Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

Admission or Observation

Patient has active outpatient status order on file

○ **Admit to Inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Level of Care:
Patient Condition:
Bed request comments:
Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

○ **Outpatient observation services under general supervision** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Attending Provider:
Patient Condition:
Bed request comments:

○ **Outpatient in a bed - extended recovery** **Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Bed request comments:

○ **Transfer patient** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Level of Care:
Bed request comments:

○ **Return to previous bed** **Frequency:** Until discontinued **Phase of Care:** Scheduling/ADT **Priority:** Routine

Admission

Patient has active status order on file

○ **Admit to inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
Admitting Physician:
Level of Care:
Patient Condition:
Bed request comments:
Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

○ **Transfer patient** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Level of Care:
Bed request comments:

○ **Return to previous bed** **Frequency:** Until discontinued **Phase of Care:** Scheduling/ADT **Priority:** Routine

Transfer

Patient has active inpatient status order on file

○ **Transfer patient** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Level of Care:
Bed request comments:

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

○ **Return to previous bed** **Frequency:** Until discontinued **Phase of Care:** Scheduling/ADT **Priority:** Routine

Code Status

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

☑ **Code Status**

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

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

Question(s):

Code Status decision reached by:

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

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

Question(s):

Did the patient/surrogate require the use of an interpreter?
Did the patient/surrogate require the use of an interpreter?
Does patient have decision-making capacity?
I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT Active until Signed by the Responsible Attending Physician.:
Code Status decision reached by:

☐ **Consult to Palliative Care Service**

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

Question(s):

Priority:
Reason for Consult?
Order?
Name of referring provider:
Enter call back number:
Reason for Consult?

Process Instructions:

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

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

Question(s):

Reason for Consult:
Reason for Consult?

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

Question(s):

Did the patient/surrogate require the use of an interpreter?
Did the patient/surrogate require the use of an interpreter?
Does patient have decision-making capacity?
Modified Code restrictions:
I acknowledge that I have communicated with the patient/surrogate/representative that the Code Status order is NOT Active until Signed by the Responsible Attending Physician.:
Code Status decision reached by:

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

☐ **Treatment Restrictions ((For use when a patient is NOT in a cardiopulmonary arrest))** **Frequency:** Continuous - Treatment Restrictions **Phase of Care:** Post-op **Priority:** Routine
Question(s):
I understand that if the patient is NOT in a cardiopulmonary arrest, the selected treatments will NOT be provided. I understand that all other unselected medically indicated treatments will be provided.:
Treatment Restriction decision reached by:
Specify Treatment Restrictions:
Code Status decision reached by:
Process Instructions:
Treatment Restrictions is NOT a Code Status order. It is NOT a Modified Code order. It is strictly intended for Non Cardiopulmonary situations.

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

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

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

Isolation

☐ **Airborne isolation status**

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

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

☐ **Contact isolation status** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Droplet isolation status** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Enteric isolation status** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

Precautions

☐ **Aspiration precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Fall precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Increased observation level needed:

☐ **Latex precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine

☐ **Seizure precautions** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Increased observation level needed:

Nursing

Vital Signs

☐ **Vital signs - T/P/R/BP** **Frequency:** Per unit protocol **Phase of Care:** Post-op **Priority:** Routine

☐ **Vital signs - T/P/R/BP** **Frequency:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine

☐ **Vital signs - T/P/R/BP** **Frequency:** Every 8 hours **Phase of Care:** Post-op **Priority:** Routine

Activity

☐ **Ambulate with assistance** **Frequency:** 3 times daily **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Specify: ○ with assistance

☐ **Must be up for meals** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Bed rest with bedside commode** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Bathroom Privileges: ○ with bedside commode

Nursing

☐ **Neurological assessment** **Frequency:** Every 8 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Assessment to Perform:

☐ **Assess operative site** **Frequency:** Every 8 hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** For bleeding

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

☐ **Cardiac output monitoring** **Frequency:** Every 15 min **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Record:

☐ **Daily weights** **Frequency:** Daily **Phase of Care:** Post-op **Priority:** Routine

☐ **Oral care** **Frequency:** Every 8 hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** While awake

☐ **Strict intake and output** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine

☐ **Head of bed 30 degrees** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Head of bed: ○ 30 degrees

☐ **Heating pad** **Frequency:** As needed **Phase of Care:** Post-op **Priority:** Routine **Comments:** To shoulder as needed for pain

☐ **Lung pillow to bedside** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Please instruct patient how to use the pillow to stabilize the chest and abdomen while coughing

☐ **Foley catheter care** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Orders: ○ Maintain ○ to gravity

☐ **Remove Foley catheter** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Chest tube to water seal** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Chest tube to continuous suction** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Level of suction: 20 cm H2O

☐ **Wound care orders** **Frequency:** Daily **Phase of Care:** Post-op **Priority:** Routine **Comments:** Change chest tube dressing. Also tape tube to flank for security. DO NOT use petroleum jelly gauze around the chest tube exit site.
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.

☐ **Setup for chest tube removal** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Comments:** Please bring to bedside: 1 biohazard bag, 1 suture removal kit, 1 16 gauge needle, 1 4 X 4 gauze, 1 petroleum jelly gauze, 1 blue chuck, 1 silk tape 2 inch

☐ **Patient education for incentive spirometry** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** For incentive spirometry
Question(s):
Patient/Family:
Education for:

☐ **Patient education for Acapella (Green flutter valve)** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** For Acapella (Green flutter valve)
Question(s):
Patient/Family:
Education for:

☐ **Patient education for deep-breathing and coughing exercises** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** For deep-breathing and coughing exercises
Question(s):
Patient/Family:
Education for:

☐ **Tobacco cessation education** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

Notify

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

☐ **Notify Physician for vitals:** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Temperature greater than: ○ 100.3 ○ 100.5
Systolic BP greater than: ○ 180 ○ 160
Systolic BP less than: 90
Diastolic BP greater than: ○ 110 ○ 100
Heart rate greater than (BPM): 100
Heart rate less than (BPM): ○ 50 ○ 60
Respiratory rate greater than: ○ 40 ○ 25
Respiratory rate less than: ○ 14 ○ 8
Temperature less than:
Diastolic BP less than: 50
MAP less than: 60.000
SpO2 less than: 92

☐ **Notify Physician for urine output** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:**
Less than 200 milliliters per shift

☐ **Notify Physician PRIOR to starting any cardiac drips** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine

☐ **Notify Physician PRIOR to transfusing blood or blood products** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine

☐ **Notify Physician PRIOR to colloid or crystalloid bolus greater than 250 mL** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine

Diet

☐ **NPO** **Frequency:** Diet effective now **Phase of Care:** Post-op **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.

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

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

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

☐ **Diet - Clear advance to 1800 Carb Control** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Diet(s): ○ Clear Liquids
Advance Diet as Tolerated? ○ Yes
Target Diet: 1800 Carb control diabetic diet
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

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

☐ **Diet - Regular** **Frequency:** Diet effective now **Phase of Care:** Post-op **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:

IV Fluids

IV Fluids

○ **sodium chloride 0.9 % infusion** **Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Question(s):
Indication(s) for Once Reason:

○ **lactated Ringer's infusion** **Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

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

○ **dextrose 5%-0.45% sodium chloride infusion** **Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

○ **sodium chloride 0.45 % infusion** **Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

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

Medications

PostOp Antibiotics

○ **ceFAZolin (ANCEF) IV** **Dose:** 1 g **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 2 Occurrences **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

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

○ **ampicillin-sulbactam (UNASYN) IV** **Dose:** 3 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Phase of Care: Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:

○ **IV Vancomycin - Medical/Surgical Prophylaxis**

☐ **Medical Prophylaxis - 24 hours** **Dose:** 15 mg/kg **Route:** intravenous **Frequency:** every 12 hours **Frequency Limit:** 24 Hours **Priority:** STAT
Question(s):
Indication: ○ Medical Prophylaxis
Medical Prophylaxis: The maximum duration of therapy that can be entered at this time is 56 days. Order can be renewed if required at that time.
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Pharmacy to automatically adjust frequency to q24h for CrCl < 45ml/min

☐ **Medical Prophylaxis - 72 hours** **Dose:** 15 mg/kg **Route:** intravenous **Frequency:** every 12 hours **Frequency Limit:** 72 Hours **Priority:** STAT
Question(s):
Indication: ○ Medical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Pharmacy to automatically adjust frequency to q24h for CrCl < 45ml/min

☐ **Vancomycin IV**

Patient Weight	Vancomycin Dose
<80 kg	1 g
80-100 kg	1.5 g
>100 kg	2 g

*Maximum pre-op dose 2 g

☑ **Weight < 80 kg**

☑ **Weight < 80 kg** **Dose:** 1 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **Weight 80-100 kg**

☑ **Weight 80-100 kg** **Dose:** 1.5 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **Weight >100 KG**

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

☑ **Weight 80-100 kg** **Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☐ **Post-Operative Surgical Prophylaxis - 1 Dose** **Dose:** 15 mg/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Surgical Prophylaxis: Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Pharmacy to automatically adjust dose based on pre-operative administration and renal function

☐ **Post-Operative Surgical Prophylaxis - 24 hours** **Dose:** 15 mg/kg **Route:** intravenous **Frequency:** every 12 hours **Frequency Limit:** 24 Hours **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Surgical Prophylaxis: Please follow institutional and service line-specific guidelines for surgical prophylaxis for the stop date/duration
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Pharmacy to automatically adjust dose based on pre-operative administration and renal function

○ **clindamycin (CLEOCIN) IV - for patient with penicillin allergy** **Dose:** 900 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Indication: Surgical Prophylaxis
Indication:

Cardiac Drips

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

☐ **sodium nitroprusside (NIPRIDE) in dextrose 5% 250 mL infusion** **Dose:** 0.3 - 8 mcg/kg/min **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op **Priority:** STAT
Admin Instructions:
START AT 2 MICROGRAMS/KILOGRAM/MINUTE (SUGGESTED RANGE 0.5-8). TITRATE TO MAINTAIN SBP LESS THAN 170 UP TO 7 MICROGRAMS/KILOGRAM/MINUTE. NOTIFY MD IF GREATER THAN 7 MICROGRAMS/KILOGRAM/MINUTE IS REQUIRED.

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

☐ **nitroglycerin infusion** **Dose:** 2 - 200 mcg/min **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op **Priority:** STAT
Admin Instructions:
START AT 2 MICROGRAMS/MIN. TITRATE FOR A MAP OF 60-70 (SUGGESTIVE RANGE LESS THAN OR EQUAL TO 10 MICROGRAMS/MIN)

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

☐ **DOBUTamine (DOBUTREX) infusion** **Dose:** 2 mcg/kg/min **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op **Priority:** STAT

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

☐ **milrinone (PRIMACOR) in dextrose 5% infusion** **Dose:** 0.125 - 0.75 mcg/kg/min **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op **Priority:** STAT
Admin Instructions:
MAINTAIN SBP GREATER THAN 90 (SUGGESTED RANGE 0.125-0.75 MICROGRAMS/KILOGRAMS PER MINUTE

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

☐ **vasopressin (PITRESSIN) infusion** **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op **Priority:** STAT

amIODarone (CORDArone) 24-hour Infusions (Hard STOP)

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

○ **CENTRAL Line Administration: amIODarone (CORDArone) 150 mg LOADING Dose followed by DOUBLE concentration 24-hour Infusion for Atrial Fibrillation**

☑ **amIODarone (CORDArone) 150 mg BOLUS Dose:** 150 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** STAT
Admin Instructions:
Patients should be monitored for QTc prolongation.
Product Admin Instructions:
May cause QTc prolongation.

☑ **amIODarone (CORDArone) 900 mg/ 250 mL NS Dose:** 1 mg/min **Route:** intravenous **Frequency:** continuous **Frequency Limit:** 6 Hours **Priority:** STAT
Admin Instructions:
Start with 1 mg/min for 6 hours. Decrease to 0.5 mg/min for 18 hours. HOLD Infusion for heart rate LESS THAN 60 or pauses GREATER THAN 2.5 seconds. MUST be infused via a CENTRAL line or PICC line.
Product Admin Instructions:
May cause QTc prolongation. Use 0.2 Micron Filter Tubing for administration.

☑ **REDUCE rate for amIODarone (CORDArone) 900 mg/ 250 mL infusion Dose:** 0.5 mg/min **Route:** intravenous **Frequency:** continuous **Frequency Limit:** 18 Hours **Priority:** STAT
Admin Instructions:
Patients should be monitored for QTc prolongation. Use in-line filter to help prevent Phlebitis. HOLD Infuson for heart rate LESS THAN 60 or pauses GREATER THAN 2.5 seconds. MUST be infused via a CENTRAL line or PICC line. Do not take down 1st infusion until entire content of bag is infused.
Product Admin Instructions:
This entry on the MAR is used to document the rate change for amiodarone infusion. *RN DO NOT USE THIS RECORD FOR RE-ORDERS*. Continuation of this IV therapy will require a new order.

○ **PERIPHERAL Line Administration: amIODarone (CORDArone) 150 mg LOADING Dose followed by 24-hour Infusion for Atrial Fibrillation - HMCCH** (Required)

☑ **amIODarone (CORDArone) 150 mg LOADING Dose Dose:** 150 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** STAT
Admin Instructions:
Patients should be monitored for QTc prolongation.
Product Admin Instructions:
May cause QTc prolongation.

☑ **amIODarone (CORDArone) 450 mg/ 250 mL infusion - 1st bag Dose:** 1 mg/min **Route:** intravenous **Frequency:** continuous **Frequency Limit:** 6 Hours **Priority:** STAT
Admin Instructions:
Start with 1 mg/min for 6 hours. Decrease to 0.5 mg/min for 18 hours. HOLD Infusion for heart rate LESS THAN 60 or pauses GREATER THAN 2.5 seconds. MUST be infused via a CENTRAL line or PICC line if infusion duration is GREATER than 24 hours.
Product Admin Instructions:
May cause QTc prolongation.

☑ **REDUCE rate for amIODarone (CORDArone) 450 mg/ 250 mL infusion Dose:** 0.5 mg/min **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Patients should be monitored for QTc prolongation. Use in-line filter to help prevent Phlebitis. HOLD Infusion for heart rate LESS THAN 60 or pauses GREATER THAN 2.5 seconds. MUST be infused via a CENTRAL line or PICC line if infusion duration is GREATER than 24 hours. Do not take down 1st infusion until entire content of bag is infused.
Product Admin Instructions:
May cause QTc prolongation. This entry on the MAR is used to document the rate change for amiodarone infusion. Continuation of this IV therapy will require a new order.

☑ **amIODarone (CORDArone) 450 mg/ 250 mL infusion - 2nd bag Dose:** 0.5 mg/min **Route:** intravenous **Frequency:** continuous **Frequency Limit:** 16 Hours **Priority:** STAT
Admin Instructions:
HOLD Infusion for heart rate LESS THAN 60 or pauses GREATER THAN 2.5 seconds. MUST be infused via a central line or PICC line if infusion duration is GREATER THAN 24 hours.
Product Admin Instructions:
May cause QTc prolongation.

○ **amIODarone (CORDArone) 900 mg/250 mL infusion**

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

☑ **amIODarone (CORDArone) 900 mg/ 250 mL NS Dose:** 1 mg/min **Route:** intravenous **Frequency:** continuous **Frequency Limit:** 6 Hours **Priority:** STAT
Admin Instructions:
Start with 1 mg/min for 6 hours. Decrease to 0.5 mg/min for 18 hours. HOLD Infusion for heart rate LESS THAN 60 or pauses GREATER THAN 2.5 seconds. MUST be infused via a CENTRAL line or PICC line if infusion duration is GREATER than 24 hours.
Product Admin Instructions:
May cause QTc prolongation. Use 0.2 Micron Filter Tubing for administration.

☑ **REDUCE rate for amIODarone (CORDArone) 900 mg/ 250 mL NS Dose:** 0.5 mg/min **Route:** intravenous **Frequency:** continuous **Frequency Limit:** 18 Hours **Priority:** STAT
Admin Instructions:
Patients should be monitored for QTc prolongation. Use in-line filter to help prevent Phlebitis. HOLD Infuson for heart rate LESS THAN 60 or pauses GREATER THAN 2.5 seconds. MUST be infused via a CENTRAL line or PICC line. Do not take down 1st infusion until entire content of bag is infused.
Product Admin Instructions:
This entry on the MAR is used to document the rate change for amiodarone infusion. *RN DO NOT USE THIS RECORD FOR RE-ORDERS*. Continuation of this IV therapy will require a new order.

○ **amIODarone (CORDArone) 900 mg/500 mL infusion - HMCCH**

☑ **amIODarone (CORDArone) 450 mg/ 250 mL infusion - 1st bag Dose:** 1 mg/min **Route:** intravenous **Frequency:** continuous **Frequency Limit:** 6 Hours **Priority:** STAT
Admin Instructions:
Start with 1 mg/min for 6 hours. Decrease to 0.5 mg/min for 18 hours. HOLD Infusion for heart rate LESS THAN 60 or pauses GREATER THAN 2.5 seconds. MUST be infused via a CENTRAL line or PICC line if infusion duration is GREATER than 24 hours.
Product Admin Instructions:
May cause QTc prolongation.

☑ **REDUCE rate for amIODarone (CORDArone) 450 mg/ 250 mL infusion Dose:** 0.5 mg/min **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Admin Instructions:
Patients should be monitored for QTc prolongation. Use in-line filter to help prevent Phlebitis. HOLD Infuson for heart rate LESS THAN 60 or pauses GREATER THAN 2.5 seconds. MUST be infused via a central line or PICC line if infusion duration is GREATER THAN 24 hours. Do not take down 1st infusion until entire content of bag is infused.
Product Admin Instructions:
May cause QTc prolongation. This entry on the MAR is used to document the rate change for amiodarone infusion. Continuation of this IV therapy will require a new order.

☑ **amIODarone (CORDArone) infusion solution -2nd bag Dose:** 0.5 mg/min **Route:** intravenous **Frequency:** continuous **Frequency Limit:** 16 Hours **Priority:** STAT
Admin Instructions:
HOLD Infusion for heart rate LESS THAN 60 or pauses GREATER THAN 2.5 seconds. MUST be infused via a central line or PICC line if infusion duration is GREATER THAN 24 hours
Product Admin Instructions:
May cause QTc prolongation.

amIODarone (PACErone) tablet

You MUST be sure the oral tablet order is set to start TOMORROW with the start time set to 24 hours AFTER the start time of the INITIAL infusion order above.

☐ **amIODarone (PACERONE) tablet **** You MUST CHANGE the START DATE to TOMORROW and set the Start TIME to be 24 hours after the Start Time of the Infusion Dose:** 200 **Route:** oral **Frequency:** every 24 hours
Admin Instructions:
amiodarone (Pacerone) tablets must start 24 hours after the start of the infusion order.
Product Admin Instructions:
May cause QTc prolongation.

Medications

☐ **docusate sodium (COLACE) capsule Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily **Phase of Care:** Post-op

☐ **calcium carbonate oyster shell (OS-CAL) tablet Dose:** 500 mg of elemental Ca **Route:** oral **Frequency:** 4 times daily **Phase of Care:** Post-op
Admin Instructions:
Note: 1,250 mg calcium carbonate = 500 mg elemental calcium

☐ **alum-mag hydroxide-simeth (MAALOX) 200-200-20 mg/5 mL suspension Dose:** 30 mL **Route:** oral **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** indigestion
Admin Instructions:
Do NOT give if patient is on hemodialysis or with CrCl < 30 mL/min.

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

☐ **simethicone (MYLICON) chewable tablet Dose:** 80 mg **Route:** oral **Frequency:** 4 times daily **Phase of Care:** Post-op

☐ **sucralfate (CARAFATE) 100 mg/mL suspension Dose:** 1 g **Route:** oral **Frequency:** every 6 hours scheduled **Phase of Care:** Post-op
Product Admin Instructions:
Take 1 hour before or 2 hours after meals**if ordered by Feeding tube Or PEG tube feeding should be stopped 1 hour before AND 1 hour after each dose.

☐ **digOXIN (LANOXIN) injection Dose:** 250 mcg/mL **Route:** intravenous **Phase of Care:** Post-op
Question(s):
Indication:
HR HOLD parameters for this order:
Contact Physician if:

☐ **digOXIN (LANOXIN) tablet Dose:** 125 mcg **Route:** oral **Phase of Care:** Post-op
Question(s):
Indication:
HR HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Monitor HR, rhythm and BP. Monitor serum potassium, magnesium, calcium, and serum creatinine.
Product Admin Instructions:
Each digoxin tablet contains 0.125 mg = 125 mcg.

☐ **metoprolol (LOPRESSOR) 5 mg/5 mL injection Dose:** 5 **Route:** intravenous **Phase of Care:** Post-op
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Hold for systolic blood pressure LESS than 110 and heart rate LESS than 60

☐ **metoprolol tartrate (LOPRESSOR) tablet Dose:** 25 **Route:** oral **Frequency:** 2 times daily **Phase of Care:** Post-op
Question(s):
BP & HR HOLD parameters for this order: ○ Hold Parameters requested
Contact Physician if:

☐ **Pain Medications**

Check Prescription Drug Monitoring Program.
Prior to initiation of opioid therapy, it is recommended to check the prescription monitoring program (PMP) database to assess patient's opioid tolerance status. A summarized version of the PMP report may be accessed by clicking on the NaRx Score on the patient's Storyboard. You may access the full version of the Texas PMP here." (https://texas.pmpaware.net/login)
Texas PMP

Due to risk of accumulation of toxic metabolite, the use of morphine in patients with renal dysfunction is not recommended. An alternative opioid should be utilized, if possible.

☐ **Scheduled Pain Medications**

Consider scheduled option if pain source is present and patient unable to reliably communicate needs.
Do not order both scheduled and PRN NSAIDs/APAP simultaneously.

○ **acetaminophen (TYLENOL) 500 mg tablet or liquid**

◉ **acetaminophen (TYLENOL) tablet Dose:** 500 mg **Route:** oral **Frequency:** every 6 hours scheduled
Question(s):
Allowance for Patient Preference:
Indication(s) for Once Reason:

◉ **acetaminophen (TYLENOL) liquid Dose:** 500 mg **Route:** oral **Frequency:** every 6 hours scheduled
Question(s):
Allowance for Patient Preference:

○ **acetaminophen (TYLENOL) 650 mg tablet or liquid**

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

◉ **acetaminophen (TYLENOL) tablet** **Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours scheduled
Question(s):
Allowance for Patient Preference:
Indication(s) for Once Reason:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL) liquid** **Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours scheduled
Question(s):
Allowance for Patient Preference:

○ **NSAIDS: For Patients LESS than 65 years old**

○ **ibuprofen (ADVIL, MOTRIN) tablet or oral suspension**

◉ **ibuprofen (ADVIL, MOTRIN) tablet** **Dose:** 600 mg **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

◉ **ibuprofen (MOTRIN) 100 mg/5 mL suspension** **Dose:** 600 mg **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot swallow tablet.
Product Admin Instructions:
Not indicated for infants under 6 months of age. Not recommended in patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet** **Dose:** 250 mg **Route:** oral **Frequency:** 2 times daily
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **celecoxib (CeleBREX) capsule** **Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily
Question(s):
Allowance for Patient Preference:
Admin Instructions:
For age LESS than 65 yo and patients GREATER than 50kg. 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.

○ **ketorolac (TORADOL) injection** **Dose:** 30 mg **Route:** intravenous **Frequency:** every 6 hours scheduled
Frequency Limit: 5 Days
Question(s):
Allowance for Patient Preference:
Admin Instructions:
For patients LESS THAN 65 years old. Not recommended for patients with eGFR LESS than 30 mL/min or acute kidney injury.

○ **NSAIDS: For Patients GREATER than or EQUAL to 65 years old**

○ **ibuprofen (ADVIL, MOTRIN) tablet or oral suspension**

◉ **ibuprofen (ADVIL, MOTRIN) tablet** **Dose:** 600 mg **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

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

◉ **ibuprofen (MOTRIN) 100 mg/5 mL suspension Dose:** 600 mg **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot swallow tablet.
Product Admin Instructions:
Not indicated for infants under 6 months of age. Not recommended in patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet Dose:** 250 mg **Route:** oral **Frequency:** 2 times daily
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **celecoxib (CeleBREX) capsule Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily
Question(s):
Allowance for Patient Preference:
Admin Instructions:
For age GREATER than or EQUAL to 65 yo and patients LESS than 50kg. 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.

○ **ketorolac (TORADOL) injection Dose:** 15 mg **Route:** intravenous **Frequency:** every 6 hours scheduled
Frequency Limit: 5 Days
Question(s):
Allowance for Patient Preference:

☐ **PRN Pain Medications**

Consider scheduled option if pain source is present and patient unable to reliably communicate needs. Monitor closely for response. Adjust dose for renal/liver function and age. Do not order both scheduled and PRN NSAIDs/APAP simultaneously. Order ONLY one short acting PO and short acting IV simultaneously. Oral option and IV options to be ordered simultaneously.

☐ **PRN Medications for Mild Pain (Pain Score 1-3): For Patients LESS than 65 years old**

Do not order both scheduled and PRN NSAIDs/APAP simultaneously.

○ **aminophen (TYLENOL) tablet OR oral suspension OR rectal suppository**

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

◉ **acetaminophen (TYLENOL) tablet Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
Question(s):
Allowance for Patient Preference:
Indication(s) for Once Reason:
Admin Instructions:
Give if patient able to swallow tablet.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL)suspension Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot tolerate oral tablet.

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

◉ **acetaminophen (TYLENOL) suppository Dose:** 650 mg **Route:** rectal **Frequency:** every 6 hours PRN
PRN Reasons: mild pain (score 1-3)
Admin Instructions:
Use if patient cannot tolerate oral tablet OR oral solution.
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **ibuprofen (ADVIL, MOTRIN) tablet or oral suspension**

◉ **ibuprofen (ADVIL, MOTRIN) tablet Dose:** 600 mg **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

◉ **ibuprofen (MOTRIN) 100 mg/5 mL suspension Dose:** 600 mg **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot swallow tablet.
Product Admin Instructions:
Not indicated for infants under 6 months of age. Not recommended in patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet Dose:** 250 mg **Route:** oral **Frequency:** every 8 hours PRN **PRN Reasons:** mild pain (score 1-3)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **celecoxib (CeleBREX) capsule Dose:** 100 mg **Route:** oral **Frequency:** 2 times daily PRN **PRN Reasons:** mild pain (score 1-3)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ketorolac (TORADOL) injection Dose:** 15 mg **Route:** intravenous **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient unable to swallow tablet.

☐ **PRN Oral Medications for Mild Pain (Pain Score 1-3): For Patients GREATER than or EQUAL to 65 years old**
Consider scheduled option if pain source is present and patient unable to reliably communicate needs. Monitor closely for response. Adjust dose for renal/liver function and age. Do not order both scheduled and PRN NSAIDs/APAP simultaneously. Order ONLY one short acting PO and short acting IV simultaneously. Oral option and IV options to be ordered simultaneously.

○ **acetaminophen (TYLENOL) tablet OR oral suspension**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

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

◉ **acetaminophen (TYLENOL) tablet Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
Question(s):
Allowance for Patient Preference:
Indication(s) for Once Reason:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

◉ **acetaminophen (TYLENOL)suspension Dose:** 650 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** mild pain (score 1-3)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot tolerate oral tablet.

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

○ **acetaminophen-codeine (TYLENOL #3) tablet OR elixir**

◉ **acetaminophen-codeine (TYLENOL WITH CODEINE #3) 300-30 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Admin Instructions:
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources). Give if patient is able to tolerate oral medication.

◉ **acetaminophen-codeine 300 mg-30 mg /12.5 mL solution Dose:** 12.5 mL **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Admin Instructions:
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources) Use if patient cannot swallow tablet.

○ **HYDROcodone-acetaminophen 5/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient able to swallow tablet.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution Dose:** 10 mL **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient unable to swallow tablet.

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

○ **oxyCODONE (ROXICODONE) immediate release tablet Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Tablets may be crushed. Give if patient able to swallow tablet
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **traMADoL (ULTRAM) tablet Dose:** 50 mg **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Max daily dose 200 mg/day in patients with CrCl < 30 ml/min. Give if patient able to swallow tablet.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

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

○ **acetaminophen-codeine (TYLENOL #3) tablet OR elixir**

◉ **acetaminophen-codeine (TYLENOL WITH CODEINE #3) 300-30 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Admin Instructions:
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources). Give if patient is able to tolerate oral medication.

◉ **acetaminophen-codeine 300 mg-30 mg /12.5 mL solution Dose:** 12.5 mL **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
The use of codeine-containing products is contraindicated in patients LESS THAN 12 years of age. Is this patient OVER 12 years of age? Y/N:
Allowance for Patient Preference:
Admin Instructions:
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources) Use if patient cannot swallow tablet.

○ **HYDROcodone-acetaminophen 5/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient able to swallow tablet.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution Dose:** 10 mL **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient unable to swallow tablet.

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

○ **oxyCODONE (ROXICODONE) immediate release tablet Dose:** 2.5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Tablets may be crushed. Give if patient able to swallow tablet
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **traMADoL (ULTRAM) tablet Dose:** 25 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Max daily dose 300mg in patients age GREATER THAN 75 years or 200 mg/day in patients with CrCl < 30 ml/min.
Give if patient able to swallow tablet.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **PRN IV Medications for Moderate Pain (Pain Score 4-6): For Patients LESS than 65 years old if unable to tolerate Oral Pain Medication.**

Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized.

○ **morPHINE injection Dose:** 2 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications.

○ **hydromorPHONE (DILAUDID) injection Dose:** 0.25 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications

○ **ketorolac (TORADOL) IV**

Do NOT use in patients with eGFR LESS than 30 mL/min.
WARNING: Use is contraindicated for treatment of perioperative pain OR in the setting of coronary artery bypass graft (CABG) surgery.

◉ **For patients ages 17-64 AND weight GREATER than or EQUAL to 50 kg AND eGFR at least 60 mL/min - ketorolac (TORADOL) injection Dose:** 30 mg **Route:** intravenous **Frequency:** every 6 hours PRN **Frequency Limit:** 5 Days **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications

☐ **PRN IV Medications for Moderate Pain (Pain Score 4-6): For Patients GREATER than or EQUAL to 65 years old if unable to tolerate Oral Pain Medication.**

Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized. (adjust dose for renal/liver function and age)

○ **morPHINE injection Dose:** 1 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications.

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

○ **hydromorPHONE (DILAUDID) injection** **Dose:** 0.25 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications

☐ **PRN Oral Medications for Severe Pain (Pain Score 7-10): For Patients LESS than 65 years old**

Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized.

○ **HYDROcodone-acetaminophen 10/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 10-325 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient able to swallow tablet.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution** **Dose:** 20 mL **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient unable to swallow tablet.

○ **morPHINE immediate-release tablet** **Dose:** 15 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Tablets may be crushed. Give if patient able to swallow tablet
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **oxyCODONE (ROXICODONE) immediate release tablet** **Dose:** 10 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Tablets may be crushed. Give if patient able to swallow tablet
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **PRN Oral Medications for Severe Pain (Pain Score 7-10): For Patients GREATER than or EQUAL to 65 years old**

Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized.

○ **oxyCODONE (ROXICODONE) immediate release tablet** **Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Oral tablets may be crushed. Give if patient able to swallow tablet
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

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

○ **morPHINE immediate-release tablet** **Dose:** 7.5 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Oral tablets may be crushed. Give if patient able to swallow tablets.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **HYDROcodone-acetaminophen 7.5/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 7.5-325 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient able to swallow tablet.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution** **Dose:** 10 mL **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient unable to swallow tablet.

○ **HYDROcodone-acetaminophen 10/325 (NORCO) tablet OR elixir**
Maximum of 4 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources)

◉ **HYDROcodone-acetaminophen (NORCO) 10-325 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient able to swallow tablet.

◉ **HYDROcodone-acetaminophen (HYCET) 2.5-108.3 mg/5 mL solution** **Dose:** 20 mL **Route:** oral **Frequency:** every 6 hours PRN
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient unable to swallow tablet.

○ **traMADoL (ULTRAM) tablet** **Dose:** 50 mg **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Max daily dose 300mg in patients age GREATER THAN 75 years or 200 mg/day in patients with CrCl < 30 ml/min.
Give if patient able to swallow tablet.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **PRN IV Medications for Severe Pain (Pain Score 7-10): For Patients LESS than 65 years old if unable to tolerate Oral Pain Medication.**

Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized.

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

○ **fentaNYL (SUBLIMAZE) injection Dose:** 25 mcg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if patient is NPO, unable to swallow oral medication, or if pain 60 minutes after giving oral pain medications.

○ **morPHINE injection Dose:** 4 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications.

○ **hydromorPHONE (DILAUDID) injection Dose:** 0.5 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Give if patient is NPO, unable to swallow oral medication, or if pain 60 minutes after giving oral pain medications.

☐ **PRN IV Medications for Severe Pain (Pain Score 7-10): For Patients GREATER than or EQUAL to 65 years old if unable to tolerate Oral Pain Medication.**
Due to risk of toxicity, the use of morphine products in patients with renal dysfunction, particularly in ESRD, is not recommended. An alternative opioid should be utilized.

○ **fentaNYL (SUBLIMAZE) injection Dose:** 12.5 mcg **Route:** intravenous **Frequency:** every 3 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if patient is NPO, unable to swallow oral medication, or if pain 60 minutes after giving oral pain medications.

○ **morPHINE injection Dose:** 2 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** severe pain (score 7-10)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Give if patient is NPO, unable to swallow oral medication, or if pain unrelieved 60 minutes after giving oral pain medications.

○ **hydromorPHONE (DILAUDID) injection Dose:** 0.25 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Give if patient is NPO, unable to swallow oral medication, or if pain 60 minutes after giving oral pain medications.

Antiemetics

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

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

◉ **ondansetron (ZOFRAN) 4 mg/2 mL injection Dose:** 4 mg **Route:** intravenous **Frequency:** every 8 hours PRN **PRN Reasons:** nausea
vomiting
Question(s):
Indication(s) for Once Reason:
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)**

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

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

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

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

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

Itching

○ **For Patients LESS than 70 years old**

☐ **diphenhydrAMINE (BENADRYL) injection Dose:** 12.5 mg **Route:** intravenous **Frequency:** every 4 hours PRN **PRN Reasons:** itching
Question(s):
Indication(s) for Once Reason:

○ **For Patients 70-76 Years Old**

☐ **cetirizine (ZyrTEC) tablet Dose:** 10 mg **Route:** oral **Frequency:** daily PRN **PRN Reasons:** itching

○ **For Patients GREATER than 77 Years Old**

☑ **cetirizine (ZyrTEC) tablet Dose:** 5 mg **Route:** oral **Frequency:** daily PRN **PRN Reasons:** itching

Insomnia: For Patients LESS than 70 years old

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

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

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

Insomnia: For patients GREATER than or EQUAL to 70 years old

○ **ramelteon (ROZEREM) tablet Dose:** 8 mg **Route:** oral **Frequency:** nightly PRN **Phase of Care:** Post-op **PRN Reasons:** sleep

VTE

VTE Risk and Prophylaxis Tool (Required)

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

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

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

○ **LOW Risk of VTE** (Required)

☑ **Low Risk** (Required)

◉ **Low risk of VTE** **Frequency:** Once **Priority:** Routine
Question(s):
Low risk: ○ Due to low risk, no VTE prophylaxis is needed. Will encourgae early ambulation ○ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

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

☑ **Moderate Risk** (Required)

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

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

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

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

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

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

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

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

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

Patient renal status: @CRCL@

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **Moderate Risk** (Required)

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

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

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

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

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

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

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

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

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

Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT), do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

○ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)
Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

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

○ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical** (Required)
Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

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

○ **aspirin chewable tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

○ **aspirin (ECOTRIN) enteric coated tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

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

☑ **apixaban (ELIQUIS) tablet Dose:** 2.5 mg **Frequency:** 2 times daily **Start Date:** S+1
Question(s):
Indications: ○ VTE prophylaxis

☑ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy Frequency:** Until discontinued **Priority:** STAT
Question(s):
Indications: VTE prophylaxis

○ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)
Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

○ **Rivaroxaban and Pharmacy Consult** (Required)

☑ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission Dose:** 10 mg **Frequency:** daily at 0600 (TIME CRITICAL)
Question(s):
Indications: ○ VTE prophylaxis
Admin Instructions:
For Xarelto 15 mg and 20 mg, give with food or follow administration with enteral feeding to increase medication absorption. Do not administer via post-pyloric routes.

☑ **Pharmacy consult to monitor rivaroxaban (XARELTO) therapy Frequency:** Until discontinued **Priority:** STAT
Question(s):
Indications: VTE prophylaxis

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

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

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

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

VTE Risk and Prophylaxis Tool

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

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

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

○ **LOW Risk of VTE** (Required)

☑ **Low Risk** (Required)

◉ **Low risk of VTE** **Frequency:** Once **Priority:** Routine
Question(s):
Low risk: ○ Due to low risk, no VTE prophylaxis is needed. Will encourgae early ambulation ○ Due to low risk, no VTE prophylaxis is needed. Will encourage early ambulation

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

☑ **Moderate Risk** (Required)

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

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

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

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

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

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

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

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

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

Patient renal status: @CRCL@

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **Moderate Risk** (Required)

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

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

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

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

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

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

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

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

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

Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT), do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **Phase of Care:** PACU & Post-op **Priority:** Routine
Question(s):
No pharmacologic VTE prophylaxis due to the following contraindication(s):

○ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)
Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

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

○ **Enoxaparin for Prophylactic Anticoagulation Nonsurgical** (Required)
Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily
Admin Instructions:
If the patient does not have a history of or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min.

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

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

○ **aspirin chewable tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

○ **aspirin (ECOTRIN) enteric coated tablet Dose:** 162 mg **Frequency:** daily **Start Date:** S+1 **Phase of Care:** PACU & Post-op

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

☑ **apixaban (ELIQUIS) tablet Dose:** 2.5 mg **Frequency:** 2 times daily **Start Date:** S+1
Question(s):
Indications: ○ VTE prophylaxis

☑ **Pharmacy consult to monitor apixaban (ELIQUIS) therapy Frequency:** Until discontinued **Priority:** STAT
Question(s):
Indications: VTE prophylaxis

○ **Enoxaparin (LOVENOX) for Prophylactic Anticoagulation** (Required)
Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

☑ **enoxaparin (LOVENOX) injection Dose:** 30 mg **Route:** subcutaneous **Frequency:** daily at 1700
Start Date: S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **ENOXAPARIN SQ DAILY**

☑ **enoxaparin (LOVENOX) injection Route:** subcutaneous **Start Date:** S+1
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **fondaparinux (ARIXTRA) injection Dose:** 2.5 mg **Route:** subcutaneous **Frequency:** daily **Start Date:** S+1
Phase of Care: PACU & Post-op
Admin Instructions:
If the patient does not have a history or suspected case of Heparin-Induced Thrombocytopenia (HIT) do NOT order this medication. Contraindicated in patients LESS than 50kg, prior to surgery/invasive procedure, or CrCl LESS than 30 mL/min

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

○ **Rivaroxaban and Pharmacy Consult** (Required)

☑ **rivaroxaban (XARELTO) tablet for hip or knee arthroplasty planned during this admission Dose:** 10 mg **Frequency:** daily at 0600 (TIME CRITICAL)
Question(s):
Indications: ○ VTE prophylaxis
Admin Instructions:
For Xarelto 15 mg and 20 mg, give with food or follow administration with enteral feeding to increase medication absorption. Do not administer via post-pyloric routes.

☑ **Pharmacy consult to monitor rivaroxaban (XARELTO) therapy Frequency:** Until discontinued **Priority:** STAT
Question(s):
Indications: VTE prophylaxis

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700
Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

☑ **Pharmacy consult to manage warfarin (COUMADIN) Frequency:** Until discontinued **Priority:** Routine
Question(s):
Indication:

☐ **warfarin (COUMADIN) tablet Dose:** 1 **Route:** oral
Question(s):
Indication:
Dose Selection Guidance:

☑ **Mechanical Prophylaxis** (Required)

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

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

Labs

STAT Labs

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

☐ **Arterial blood gas Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** PACU **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☐ **Prothrombin time with INR Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** PACU **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☐ **Partial thromboplastin time** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** PACU **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 **Phase of Care:** PACU **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Tomorrow

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

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

☐ **Blood gas, arterial** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

X-Ray

☐ **Chest 1 Vw** **Frequency:** 1 time imaging **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Chest Pa Lateral W Fluoroscopy** **Frequency:** 1 time imaging **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Chest 1 Vw Portable** **Frequency:** 1 time imaging **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Cardiology

Imaging

Other Studies

Other Diagnostic Studies

☐ **Echocardiogram transesophageal** **Frequency:** 1 time imaging **Phase of Care:** Post-op **Priority:** Routine **Comments:** NPO 6 hours prior to exam
Question(s):
What is the patients sedation requirement?
Where should test be performed?
Does this exam need a bubble study?
Preferred interpreting Cardiologist or group:

Respiratory

Respiratory

☐ **Oxygen therapy** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Initial Device:
Device:
SpO2 Goal: 93% - 98%
SpO2 Goal: 93% - 96%
Titrate FiO2 to keep O2 saturations:
Notify Physician if:
Indications for O2 therapy:
Indications for O2 therapy:
Primary Ordering Comments:
@CERMSG(661071:25704)@

☐ **Extubate** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine

☐ **Incentive spirometry instructions** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Frequency of use:

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

☐ **Mechanical ventilation** **Frequency:** Continuous **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Mechanical Ventilation:
Vent Management Strategies: Adult Respiratory Ventilator Protocol

☐ **PEP** **Frequency:** As directed **Phase of Care:** Post-op **Priority:** Routine **Comments:** 20 times every hour while awake

Rehab

Consults

For Physician Consult orders use sidebar

Ancillary Consults

☐ **Consult to Case Management** **Frequency:** Once **Phase of Care:** Post-op **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 **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for Consult:
Reason for Consult?

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

☐ **Consult to PT eval and treat** **Frequency:** Once **Phase of Care:** Post-op **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 OT eval and treat** **Frequency:** Once **Phase of Care:** Post-op **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 **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason For Consult?
Purpose/Topic:
Reason for Consult?

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

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

☐ **Consult to Speech Language Pathology** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for consult:
Reason for SLP?

☐ **Consult to Wound Ostomy Care nurse** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for consult:
Reason for consult:
Reason for consult:
Reason for consult:
Consult for NPWT:
Reason for consult:
Reason for consult:
Reason for Consult?
Process Instructions:
This is NOT for PT Wound Care Consult order.

☐ **Consult to Respiratory Therapy** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Reason for Consult?
Reason for Consult?

Additional Orders

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