Vascular Surgery Post-Op Floor (2072)

Version: 14 **Gen:** 10/26/2026

Location: _____

General

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:

○ **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

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

○ **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:

○ **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?

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

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

☐ **Treatment Restrictions ((For use when a patient is NOT in a cardiopulmonary arrest))** **Frequency:** Continuous - Treatment Restrictions **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.

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:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** Pulse check q2 x12 then every 4 hours if patient is stable. Notify MD if absent pulse or doppler signals or change in vascular exam.

Activity

☑ **Up with assistance to chair** **Frequency:** Daily **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Comments:** Out of bed to chair with assistance
Question(s):
Specify: ○ Out of bed ○ Up in chair ○ Up with assistance

☐ **Ambulate** **Frequency:** 4 times daily **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Specify: ○ with assistance

☐ **Bed rest - lay flat for 6 hrs** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Patient must lay flat for 6 hours post-op
Question(s):
Bathroom Privileges:

☐ **Bed rest** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine

☐ **Bed rest - lay flat for 4 hrs** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Patient must lay flat for 4 hours post-op

Nursing

☐ **Intake and output** **Frequency:** Every 4 hours **Phase of Care:** Post-op **Priority:** Routine

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

☐ **Remove Foley catheter** **Frequency:** Once **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine

☑ **Soft heel protection boots** **Frequency:** Until discontinued **Priority:** Routine **Comments:** Place on patient while in bed.

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

☐ **Nasogastric tube maintenance** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine
Comments: Irrigate with 30 cubic cm of saline q4
Question(s):
Tube Care Orders: ○ To Continuous Suction

☐ **Drain care** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Clean site with betadine and change dressing daily. Strip tubing every shift and empty drain and record output every shift and as needed.
Question(s):
Drain 1: ○ Jackson Pratt
Drainage/Suction: ○ To Compression (Bulb) Suction ○ Strip tubing
Drain 2:
Drain 3:
Drain 4:
All Drains:

☐ **Neurological assessment** **Frequency:** Every 2 hours **Frequency Limit:** 6 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Comments:** Post CEA
Question(s):
Assessment to Perform:

☐ **Assess operative site** **Frequency:** Every 6 hours **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Comments:** Now and then every 6 hours for the first 24 hours. If patient is status post Carotid Endarterectomy, monitor neck incision for increased swelling, hematoma formation, difficulty swallowing or difficulty speaking.

☐ **Assess operative site** **Frequency:** Every 6 hours **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Comments:** Now and then every 6 hours for the first 24 hours. If status post angiogram, monitor angiogram access site for hematoma formation. Mark demarcation of hematoma at time of arrival to unit bed. Notify surgical team if any marked changes or abnormalities to site.

☐ **Wound care orders** **Frequency:** Every 12 hours **Priority:** Routine **Comments:** Do not remove dressings until 48 hours post-op. Heavy betadine paint to all incisions daily (unless dermabond). Report dehiscence and abnormalities to surgical team. If groin incision is present, cover with gauze and tape.
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.

☐ **Have wound dressings available at bedside** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Have wound dressings available at bedside
Question(s):
Supplies:

☐ **No peripheral IV or blood draws on side of anticipated dialysis access, place sign over patient's bed** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☑ **Elevate extremity** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Additional instructions: ○ elevate extremity
Position:

☐ **Nursing communication: OK to cannulate AV access for dialysis** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Nursing communication: OK to resume heparin post-op** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Nursing communication: Discontinue heparin post-op** **Frequency:** Until discontinued **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: ○ 38.5 ○ 100.5
Systolic BP greater than: 160
Systolic BP less than: 90
Diastolic BP greater than: 100
MAP less than: ○ 60 ○ 60.000
Heart rate greater than (BPM): 100
Heart rate less than (BPM): ○ 50 ○ 60
Respiratory rate greater than: 25
Respiratory rate less than: 8
SpO2 less than: ○ 94 ○ 92
Temperature less than:
Diastolic BP less than: 50

☐ **Notify Vascular Surgery team for urine output less than 30 milliliters/hour** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Notify Vascular Surgery team absent pulses or Doppler signals or change in the vascular exam** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

Diet

☐ **NPO** **Frequency:** Diet effective midnight **Phase of Care:** Post-op **Priority:** Routine
Question(s):
NPO: ○ Except meds
Pre-Operative fasting options:
Process Instructions:
An NPO order without explicit exceptions means nothing can be given orally to the patient.

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

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

☐ **Diet - Renal** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Diet(s): ○ Renal (80GM Pro, 2-3GM Na, 2-3GM K)
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

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

☐ **Diet - 1800 Kcal / 202 GM Carbohydrate** **Frequency:** Diet effective now **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Diet(s): ○ Consistent Carbohydrate
Consistent Carbohydrate: 1800 Kcal/202 gm Carbohydrate
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

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

IV Fluids

☐ **Post-Procedure Hydration**

○ **Inpatient**

○ **sodium chloride 0.9% infusion** **Dose:** 125 mL/hr **Frequency:** continuous
Question(s):
Indication(s) for Once Reason:

○ **sodium chloride 0.9% infusion** **Dose:** .9 **Frequency:** continuous
Question(s):
Indication(s) for Once Reason:

○ **Inpatient**

○ **sodium chloride 0.9% infusion** **Dose:** 125 mL/hr **Frequency:** continuous
Question(s):
Indication(s) for Once Reason:

○ **sodium chloride 0.9% infusion** **Dose:** .9 **Frequency:** continuous
Question(s):
Indication(s) for Once Reason:

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

Anti-hypertensives

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

☐ **hydrALAZINE (APRESOLINE) injection Dose:** 10 mg **Route:** intravenous **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Comment:** SBP GREATER than 140 mmHg **PRN Reasons:** high blood pressure
Question(s):
Hold for Heart Rate GREATER than (in bpm): 100
BP HOLD parameters for this order:
Indication(s) for Once Reason:
Contact Physician if:
Admin Instructions:
Hold if heart rate is GREATER than 100.

☐ **labetalol (TRANDATE) injection Dose:** 10 mg **Route:** intravenous **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Comment:** SBP GREATER than 140 mmHg **PRN Reasons:** high blood pressure
Question(s):
BP & HR HOLD parameters for this order: BP & HR HOLD Parameters requested
BP & HR HOLD for: Heart Rate LESS than 60 bpm
Admin Instructions:
hold for heart rate LESS than 60.

Anti-platelets

☐ **aspirin (ECOTRIN) enteric coated tablet Dose:** 81 **Route:** oral **Frequency:** daily **Phase of Care:** Post-op

☐ **clopidogrel (PLAVIX) tablet Dose:** 300 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op

☐ **clopidogrel (PLAVIX) tablet Dose:** 75 mg **Route:** oral **Frequency:** daily **Start Date:** S+1 **Phase of Care:** Post-op

Statin Therapy

○ **rosuvastatin (CRESTOR) tablet Dose:** 10 mg **Route:** oral **Frequency:** nightly **Phase of Care:** Post-op

○ **rosuvastatin (CRESTOR) tablet Dose:** 20 mg **Route:** oral **Frequency:** nightly **Phase of Care:** Post-op

○ **atorvastatin (LIPITOR) tablet Dose:** 10 mg **Route:** oral **Frequency:** nightly **Phase of Care:** Post-op

○ **atorvastatin (LIPITOR) tablet Dose:** 40 mg **Route:** oral **Frequency:** nightly **Phase of Care:** Post-op

☐ **Anti-coagulation**

☐ **Pharmacy Consult to Manage Heparin: STANDARD dose protocol (DVT/PE) - with titration boluses Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** STAT
Question(s):
Heparin Indication:
Specify:
Specify:
Monitoring:
Process Instructions:
Standard Dose Protocol

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

See protocol for details

☐ **HEParin 25,000 unit/500 mL (50 unit/mL) Dose:** 500 Units/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Question(s):
Indication:
Therapeutic Monitoring Target:

☐ **Resume heparin**

○ **Ok to resume heparin post-op Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine

○ **Discontinue heparin post-op Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine

☐ **Heparin bolus and infusion**

☐ **HEParin (porcine) injection Dose:** 80 Units/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** STAT

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

☐ **HEParin 25,000 unit/500 mL (50 unit/mL)** **Dose:** 500 Units/hr **Route:** intravenous **Frequency:** continuous **Priority:** STAT
Question(s):
Indication: ○ Peripheral vascular disease
Therapeutic Monitoring Target: ○ PTT - Other
Specify Target: None - Non-titrated

☐ **enoxaparin (LOVENOX)** **Dose:** 1 mg/kg **Route:** subcutaneous **Frequency:** every 12 hours **Phase of Care:** Post-op
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.

☐ **For renal impairment (GFR <30) - enoxaparin (LOVENOX)** **Dose:** 1 mg/kg **Route:** subcutaneous **Frequency:** daily at 1700 **Phase of Care:** Post-op
Question(s):
Indication(s):
Admin Instructions:
FOR PATIENTS WITH CRCL OF LESS THAN 30 MILLILITERS PER MINUTE OR PATIENTS WITH ESRD.
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

☐ **Pharmacy consult to manage warfarin (COUMADIN)** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Indication:

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.:

○ **If Beta-Lactam Allergic - vancomycin (VANCOCIN) IV** **Dose:** 1 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.:
Admin Instructions:
Start 12 hours post Pre-Op dose and HOLD if CrCl < 30 mL/min.

Multi-modal pain regimen

☐ **acetaminophen (OFIRMEV) injection and/or lidocaine 5% patch**

○ **acetaminophen (OFIRMEV) intravenous solution** **Dose:** 1000 mg **Route:** intravenous **Frequency:** every 8 hours **Frequency Limit:** 2 Occurrences **Phase of Care:** Post-op
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied: IV acetaminophen (Ofirmev) is restricted to use only in OR, PACU, or ICU areas, and for patients that cannot tolerate oral, per tube, or rectal routes of administration. Do you attest that this restriction has been met?
Allowance for Patient Preference:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **acetaminophen (OFIRMEV) intravenous solution** **Dose:** 1000 mg **Route:** intravenous **Frequency:** once PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied: IV acetaminophen (Ofirmev) is restricted to use only in OR, PACU, or ICU areas, and for patients that cannot tolerate oral, per tube, or rectal routes of administration. Do you attest that this restriction has been met?
Allowance for Patient Preference:
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

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

○ **lidocaine (LIDODERM) 5 % Dose:** 2 patch **Route:** transdermal **Frequency:** every 24 hours **Frequency Limit:** 4 Occurrences **Phase of Care:** Post-op
Admin Instructions:
Specify Site: ***
Product Admin Instructions:
Apply to affected area. Remove patch 12 hours after applying.

☐ **gabapentin (NEURONTIN) capsule**

○ **GFR GREATER than 60 - gabapentin 300 mg PO TID x 5 days Dose:** 300 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **GFR BETWEEN 30-60 - gabapentin 200 mg PO TID x 5 days Dose:** 200 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **GFR BETWEEN 15-30 - gabapentin 100 mg PO TID x 5 days Dose:** 100 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **GFR LESS THAN 15 or on dialysis - gabapentin 100 mg PO TID x 5 days Dose:** 100 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

☐ **pregabalin (LYRICA) capsule**

○ **GFR GREATER than 60 - pregabalin 50 mg PO TID x 5 days Dose:** 50 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **GFR BETWEEN 30-60 - pregabalin 25 mg PO TID x 5 days Dose:** 25 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **GFR BETWEEN 15-30 - pregabalin 25 mg PO BID x 5 days Dose:** 25 mg **Route:** oral **Frequency:** 2 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **GFR LESS than 15 or on dialysis - pregabalin 25 mg PO BID x 5 days Dose:** 25 mg **Route:** oral **Frequency:** 2 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

☐ **tramadol (ULTRAM) tablet**

○ **GFR GREATER than 60 - traMADoL 100 mg PO Q8H Dose:** 100 mg **Route:** oral **Frequency:** every 8 hours **Phase of Care:** Post-op
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **GFR BETWEEN 30-60 - traMADoL 50 mg PO Q8H Dose:** 50 mg **Route:** oral **Frequency:** every 8 hours **Phase of Care:** Post-op
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **Elderly Age GREATER than 75 years old - traMADoL 50 mg PO Q8H Dose:** 50 mg **Route:** oral **Frequency:** every 8 hours **Phase of Care:** Post-op
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

☐ **PRN Breakthrough Pain**

○ **oxyCODone (ROXICODONE) immediate release tablet Dose:** 10 mg **Route:** oral **Frequency:** every 4 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

○ **hydromorPHONE (DILAUDID) injection Dose:** 0.5 mg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)

○ **morPHINE injection Dose:** 2 mg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Indication(s) for Once Reason:

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

☐ **methocarbamol (ROBAXIN) tablet Dose:** 500 mg **Route:** oral **Frequency:** 3 times daily PRN **Phase of Care:** Post-op **PRN Comment:** or pain control **PRN Reasons:** muscle spasms

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

(adjust dose for renal/liver function and age)

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

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

◉ **acetaminophen-codeine (TYLENOL #3) 300-30 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
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:
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 **PRN Reasons:** moderate pain (score 4-6)
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:
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 **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
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 **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
If patient cannot swallow tablet.

○ **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 **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

◉ **HYDROcodone-acetaminophen (HYCET) 7.5-325 mg/15 mL solution Dose:** 15 mL **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient cannot 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)

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

◉ **HYDROcodone-acetaminophen (NORCO 10-325) mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication.

◉ **HYDROcodone-acetaminophen (HYCET) 7.5-325 mg/15 mL solution Dose:** 20 mL **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Use if patient can not swallow tablet.

○ **traMADol (ULTRAM) tablet - For eGFR LESS than 30 mL/min, change frequency to every 12 hours) Dose:** 50 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
(Max Daily dose not to exceed 200 mg/day).

Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

PRN Oral for Moderate Pain (Pain Score 4-6): For Patients GREATER than 65 years old

NOTICE: Before any pain medication is used you MUST NOTIFY MD and get approval.
(adjust dose for renal/liver function and age)

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

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

◉ **acetaminophen-codeine (TYLENOL #3) 300-30 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **PRN Reasons:** moderate pain (score 4-6)
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:
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 **PRN Reasons:** moderate pain (score 4-6)
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:
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 **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
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 **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
If patient cannot swallow tablet.

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

◯ **traMADol (ULTRAM) tablet - For eGFR LESS than 30 mL/min, change frequency to every 12 hours) Dose:** 25 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
(Max Daily dose not to exceed 200 mg/day). Give if patient can tolerate oral medication.
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

PRN IV for Moderate Pain (Pain Score 4-6): For Patients LESS than 65 years old

If you select a PCA option you will not be allowed to also order IV PRN pain medications from this section.
(adjust dose for renal/liver function and age)

◯ **fentaNYL (SUBLIMAZE) injection Dose:** 25 mcg **Route:** intravenous **Frequency:** every 2 hour PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

◯ **morphine 2 mg/mL injection Dose:** 2 mg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

◯ **HYDROmorphone (DILAUDID) injection Dose:** 0.5 mg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

PRN IV for Moderate Pain (Pain Score 4-6): For Patients GREATER than 65 years old

If you select a PCA option you will not be allowed to also order IV PRN pain medications from this section.
(adjust dose for renal/liver function and age)

◯ **fentaNYL (SUBLIMAZE) injection Dose:** 12.5 mcg **Route:** intravenous **Frequency:** every 2 hour PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

◯ **morphine 2 mg/mL injection Dose:** 1 mg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

◯ **HYDROmorphone (DILAUDID) injection Dose:** 0.2 mg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** moderate pain (score 4-6)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

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

(adjust dose for renal/liver function and age)

◯ **HYDROmorphone (DILAUDID) tablet Dose:** 2 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

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

◯ **morphine (MSIR) tablet Dose:** 15 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule. Do not crush, split, or chew.

◯ **oxyCODONE (ROXICODONE) immediate release tablet Dose:** 10 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

PRN Oral for Severe Pain (Pain Score 7-10): For Patients GREATER than 65 years old
(adjust dose for renal/liver function and age)

◯ **HYDROcodone-acetaminophen (NORCO) 7.5-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

◯ **HYDROcodone-acetaminophen (NORCO 10-325) 10-325 mg per tablet Dose:** 1 tablet **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication

◯ **HYDROmorphone (DILAUDID) tablet Dose:** 2 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

◯ **morphine (MSIR) tablet Dose:** 15 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule. Do not crush, split, or chew.

◯ **oxyCODONE (ROXICODONE) immediate release tablet Dose:** 5 mg **Route:** oral **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Give if patient is able to tolerate oral medication
Product Admin Instructions:
Give if patient can receive oral tablet/capsule.

PRN IV for Severe Pain (Pain Score 7-10): For Patients LESS than 65 years old
If you select a PCA option you will not be allowed to also order IV PRN pain medications from this section.
(adjust dose for renal/liver function and age)

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

◯ **fentaNYL (SUBLIMAZE) injection Dose:** 50 mcg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

◯ **morphine injection Dose:** 4 mg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

◯ **HYDROmorphone (DILAUDID) injection Dose:** 0.8 mg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

PRN IV for Severe Pain (Pain Score 7-10): For Patients GREATER than 65 years old

If you select a PCA option you will not be allowed to also order IV PRN pain medications from this section. (adjust dose for renal/liver function and age)

◯ **fentaNYL (SUBLIMAZE) injection Dose:** 25 mcg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

◯ **morphine injection Dose:** 2 mg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Question(s):
Indication(s) for Once Reason:
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

◯ **HYDROmorphone (DILAUDID) injection Dose:** 0.5 mg **Route:** intravenous **Frequency:** every 3 hours PRN **Phase of Care:** Post-op **PRN Reasons:** severe pain (score 7-10)
Admin Instructions:
Use if patient is unable to swallow or faster onset is needed

PCA Medications - Opioid Naive

◯ **morPHINE PCA 30 mg/30 mL Dose:** 3 **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Admin Instructions:
Management of breakthrough pain. Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber. For breakthrough pain in patients ages 19-59 years old with normal renal function, may bolus {Bolus Dose:26657::"2"} mg every {Bolus Frequency:26659::"3"} hours as needed. If pain persists, may increase PCA demand dose by {PCA Dose:26660::"0.5"} mg ONCE. Adjust doses for age, renal function or other factors.

◯ **hydromorPHONE (DILAUDID) 15 mg/30 mL PCA Dose:** .5 **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Admin Instructions:
Management of breakthrough pain. Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber. For breakthrough pain in patients ages 19-59 years old with normal renal function, may bolus {Bolus Dose:26662::"0.2"} mg every {Bolus Frequency:26663::"3"} hours as needed. If pain persists, may increase PCA demand dose by {PCA Dose:26664::"0.1"} mg ONCE. Adjust doses for age, renal function or other factors.

◯ **fentaNYL (SUBLIMAZE) 1500 mcg/30 mL PCA Dose:** 50 **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Admin Instructions:
Management of breakthrough pain. Administer only if respiratory rate 12 per minute or more and POSS level of 2 or less. If more than 2 bolus doses in 12 hours or if pain persists after increase in demand dose, call ordering prescriber. For breakthrough pain in patient 19-59 years old, may bolus {Bolus Dose:26656::"25"} mcg every {Bolus Frequency:26655::"2"} hours as needed. If pain persists, may increase PCA demand dose by {PCA Dose:26654::"10"} mcg ONCE. Adjust doses for age, renal function or other factors.

Nausea

☐ **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)**

◉ **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.

Bowel regimen - Scheduled

◉ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** 2 times daily **Phase of Care:** Post-op **PRN Reasons:** constipation

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

○ **bisacodyl (DULCOLAX) suppository** **Dose:** 10 mg **Route:** rectal **Frequency:** daily **Phase of Care:** Post-op **PRN Reasons:** constipation

○ **polyethylene glycol (MIRALAX) packet 17 gram** **Dose:** 17 g **Route:** oral **Frequency:** daily **Phase of Care:** Post-op
Product Admin Instructions:
Mix in 4-8oz of water.

Bowel regimen - PRN

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

○ **bisacodyl (DULCOLAX) suppository** **Dose:** 10 mg **Route:** rectal **Frequency:** daily PRN **Phase of Care:** Post-op **PRN Reasons:** constipation

○ **sennosides-docusate sodium (SENOKOT-S) 8.6-50 mg per tablet** **Dose:** 1 tablet **Route:** oral **Frequency:** 2 times daily PRN **Phase of Care:** Post-op **PRN Reasons:** constipation

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

○ **polyethylene glycol (MIRALAX) packet 17 gram** **Dose:** 17 g **Route:** oral **Frequency:** daily PRN **Phase of Care:** Post-op
PRN Reasons: constipation
Product Admin Instructions:
Mix in 4-8oz of water.

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	

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

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)

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

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

☑ **Place sequential compression device**

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

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

○ **LOW Risk of VTE** (Required)

☑ **Low Risk** (Required)

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

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 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):

○ **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@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

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

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

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

- ○ **HEParin (porcine) injection - Q12 Hours Dose:** 5000 Units **Frequency:** every 12 hours scheduled
- ○ **HEParin (porcine) injection - Q8 Hours Dose:** 5000 Units **Frequency:** every 8 hours scheduled

○ **Not high bleed risk**

- ○ **Wt > 100 kg Dose:** 7500 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled
- ○ **Wt LESS than or equal to 100 kg Dose:** 5000 Units **Route:** subcutaneous **Frequency:** every 8 hours scheduled

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

○ **Contraindications exist for pharmacologic prophylaxis Frequency:** Once **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:_____

- [x] **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

- [x] **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:

- [x] **Place sequential compression device**

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

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

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

- [x] **Moderate risk of VTE** **Frequency:** Once **Priority:** Routine

- [x] **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:

- [x] **Place sequential compression device**

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

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

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

- [x] **High risk of VTE** **Frequency:** Once **Priority:** Routine

- [x] **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:

- [x] **Place sequential compression device**

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

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

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

- [x] **High risk of VTE** **Frequency:** Once **Priority:** Routine

- [x] **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:

- [x] **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):

Labs

Laboratory Today

☐ **CBC with platelet and differential Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Basic metabolic panel Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Prothrombin time with INR Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☐ **Partial thromboplastin time** **Frequency:** Once **Phase of Care:** Post-op **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.

☐ **Magnesium level** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Laboratory Tomorrow

☑ **CBC with platelet and differential** **Frequency:** AM draw repeats **Frequency Limit:** 3 Occurrences **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☐ **Prothrombin time with INR** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Partial thromboplastin time** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **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.

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

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

☐ **Hemoglobin A1c** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

Cardiology

Imaging

HM IP XRAY VASCULAR FL

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

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

☐ **XR Chest 1 Vw Portable - AM** **Frequency:** 1 time imaging **Start Date:** S+1 **Start Time:** 0600 **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.):

☐ **XR Abdomen 1 Vw Portable - AM** **Frequency:** 1 time imaging **Start Date:** S+1 **Start Time:** 0600 **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.):

Other Studies

Respiratory

Rehab

Consults

For Physician Consult orders use sidebar

Ancillary Consults

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

☐ **Consult to Case Management - Rehab referral** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine **Comments:** Status post amputation
Question(s):
Reason for Consult? ○ Rehab Referral
Consult Reason:
Process Instructions:
If Ordering IV antimicrobial therapy, an additional consult to Case Management OPAT order is needed.

☐ **Consult to Case Management - Home health** **Frequency:** Once **Priority:** Routine
Question(s):
Consult Reason: ○ Home Health
Home Health Services: ○ Home Wound Care ○ Skilled Nursing Evaluation & Treatment
Wound care questions: Wound vac
Pressure (mmHg): 125
Therapy Settings: Continuous
Foam Type: Black
Type of Wound: Surgical Wound
Clinical Findings: Other:
Other Clinical Findings: wound vac
Homebound Status: Weakness and fatigue post hospitalization
Reason for Consult?
Process Instructions:
If Ordering IV antimicrobial therapy, an additional consult to Case Management OPAT order is needed.

☑ **Consult 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 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 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?

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

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

☐ **Consult 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 Nephrology** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

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

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

☐ **Consult Diabetes/Endocrinology** **Frequency:** Once **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

Additional Orders

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