Vascular Surgery Post-Op to ICU (2074)

Version: 21 **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.

Isolation

☐ **Airborne isolation status**

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

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

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

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

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

Precautions

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

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

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

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

Nursing

Vital Signs

☑ **Vital signs - T/P/R/BP** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine **Comments:** Peripheral (palpation and Doppler) every 15 minutes x4, then every 30 minutes x4, then hourly.

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: ○ Up with assistance ○ Up in chair ○ Out of bed

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

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

☐ **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 hour **Phase of Care:** Post-op **Priority:** Routine **Comments:** Measure UOP hourly and notify vascular team for UOP less than 30 ml/hr.

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

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

☐ **Foley catheter care** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Remove Foley cath POD *** Activate nursing protocol NUR 12D4 Document reason for not removing Foley. (Must be documented on POD 1 or POD 2)
Question(s):
Orders: Maintain

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

☐ **Peripheral vascular assessment** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine **Comments:** As required for revascularized limb

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

☐ **Spinal drain care** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Follow CVICU spinal drain protocol.
Question(s):
Drain 1:
Drain 2:
Drain 3:
Drain 4:
All Drains:

☐ **Drain care** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Clean site with betadine and change dressing daily, strip tubing every 6 hours, and empty drain and record output every 6 hours 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:

☐ **Measure drainage** **Frequency:** Every 6 hours **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Type of drain: ○ Jackson Pratt

☐ **Elevate extremity** **Frequency:** Until discontinued **Start Date:** S+1 **Phase of Care:** Post-op **Priority:** Routine **Comments:** Elevate effected extremity.
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

☐ **Soft heel protection boots** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Place on patient while in bed.

☐ **OK to use TDC** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

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

☐ **Blood pressure management** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** MAPs 90-100 for thoracic endograft.

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

Notify

☐ **Notify Vascular Surgery team for paraplegia** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☐ **Notify Vascular Surgery team if fibrinogen is less than 200** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine

☑ **Notify Physician for vitals:** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** Urine output less than 30 milliliters/hour. Absent pulses or Doppler signals or change in the vascular exam. Change in motorsensory/vascular exam
Question(s):
Temperature greater than: ○ 38.5 ○ 100.5
Systolic BP greater than: 160
Systolic BP less than: 90
Diastolic BP greater than: 100
Diastolic BP less than: 50
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:

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:

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

☐ **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:

☐ **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**

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

○ **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
Question(s):
Indication(s) for Once Reason:

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

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

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

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

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

Medications

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.

☐ **Multimodal Pain**

☐ **acetaminophen (OFIRMEV) intravenous solution (RESTRICTED) 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:
Admin Instructions:
IV acetaminophen is restricted to use in patients that cannot tolerate oral, per tube, or rectal routes of administration, and is only approved for post-operative use. If patient status allows, please utilize an alternate route of administration of acetaminophen.
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 (RESTRICTED) 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:
Admin Instructions:
IV acetaminophen is restricted to use in patients that cannot tolerate oral, per tube, or rectal routes of administration, and is only approved for post-operative use. If patient status allows, please utilize an alternate route of administration of acetaminophen.
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) patch**

☑ **lidocaine (LIDODERM) 5 % Dose:** 1 patch **Route:** transdermal **Frequency:** every 24 hours
Admin Instructions:
Remove after 12 hours (do not give to patients with adhesive sensitivity or allergies to lidocaine).
Product Admin Instructions:
Apply to affected area. Remove patch 12 hours after applying.

☐ **Gabapentinoids**

○ **Gabapentin**

○ **gabapentin (NEURONTIN) capsule (CrCl greater than or equal to 60 mL/min) Dose:** 300 mg **Route:** oral **Frequency:** every 8 hours scheduled **Phase of Care:** Post-op

○ **gabapentin (NEURONTIN) capsule (CrCl 30-59 mL/min) Dose:** 200 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **gabapentin (NEURONTIN) capsule (CrCl 15-29 mL/min) Dose:** 100 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **gabapentin (NEURONTIN) capsule (CrCl less than 15 or on dialysis) Dose:** 100 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **pregabalin (LYRICA)**

○ **pregabalin (LYRICA) capsule (CrCl 60 mL/min or above) Dose:** 300 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **pregabalin (LYRICA) capsule (CrCl 30-59 mL/min) Dose:** 200 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **pregabalin (LYRICA) capsule (CrCl 15-29 mL/min) Dose:** 100 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

○ **pregabalin (LYRICA) capsule (CrCl less than 15 mL/min or on dialysis) Dose:** 100 mg **Route:** oral **Frequency:** 3 times daily **Frequency Limit:** 5 Days **Phase of Care:** Post-op

☐ **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:

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.

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

◉ **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)

◉ **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.

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

○ **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.

○ **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)

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

○ **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.

○ **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.

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

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)

- ○ **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.

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

(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.

Respiratory

☐ **Scheduled - albuterol nebulizer Dose:** 2.5 mg **Route:** nebulization **Frequency:** Respiratory Therapy - every 6 hours **Phase of Care:** Post-op
Question(s):
Aerosol Delivery Device:

☐ **As needed - albuterol nebulizer Dose:** 2.5 mg **Route:** nebulization **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** wheezing
Question(s):
Aerosol Delivery Device:

☐ **Scheduled - ipratropium nebulizer Dose:** 0.5 mg **Route:** nebulization **Frequency:** Respiratory Therapy - every 6 hours **Phase of Care:** Post-op
Question(s):
Aerosol Delivery Device:

☐ **As needed - ipratropium nebulizer Dose:** 0.5 mg **Route:** nebulization **Frequency:** every 6 hours PRN **Phase of Care:** Post-op **PRN Reasons:** wheezing
Question(s):
Aerosol Delivery Device:

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

☑ **Incentive spirometry instructions** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Frequency of use: ○ Every 2 hours while awake

Anti-hypertensives

☐ **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

☐ **Anticoagulation**

○ **Pharmacy Consult to Manage Heparin: STANDARD dose protocol (DVT/PE) - with titration boluses** **Frequency:** Until discontinued **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:

○ **Heparin bolus and infusion**

☐ **HEParin (porcine) injection** **Dose:** 80 Units/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Start Date:** S **Phase of Care:** Post-op
Question(s):
Therapeutic Monitoring Target: PTT - 61 - 112 sec

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

☐ **HEParin 25,000 unit/500 mL (50 unit/mL)** **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Question(s):
Indication: ○ Peripheral vascular disease
Therapeutic Monitoring Target: ○ PTT - Other
Specify Target: None - Non-titrated

☐ **Partial thromboplastin time, activated X 3** **Frequency:** Every 6 hours **Frequency Limit:** 3 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.

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 - 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

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

○ **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

○ **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.

Thrombolysis

Catheter-Directed Thrombolysis

○ **EKOS**

☐ **RIGHT - alteplase + heparin + sodium chloride**

☑ **RIGHT - alteplase 8 mg in 240 mL NS** **Dose:** 1 mg/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☑ **RIGHT - HEParin 25,000 unit/500 mL (50 unit/mL) in D5W Premix** **Dose:** 250 Units/hr **Route:** intravenous **Frequency:** titrated **Phase of Care:** Post-op
Question(s):
Indication:
Therapeutic Monitoring Target:

☑ **sodium chloride 0.9 % infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Question(s):
Indication(s) for Once Reason:

☐ **LEFT - alteplase + heparin + sodium chloride**

☑ **LEFT - alteplase 8 mg in 240 mL NS** **Dose:** 1 mg/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☑ **LEFT - HEParin 25,000 unit in 500 mL in d5w** **Dose:** 250 Units/hr **Route:** intravenous **Frequency:** titrated **Phase of Care:** Post-op
Question(s):
Indication:
Therapeutic Monitoring Target:

☑ **sodium chloride 0.9 % infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
Question(s):
Indication(s) for Once Reason:

☑ **Nursing and Labs**

☑ **Fibrinogen** **Frequency:** Now then every 4 hours **Frequency Limit:** 3 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Partial thromboplastin time, activated** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Start Date:** S+1 **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.

☑ **CBC with Platelet and Differential** **Frequency:** Every 12 hours **Frequency Limit:** 2 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Please hold all Anticoagulants while therapy in progress** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine

☑ **Strict bed rest** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine

☑ **Peripheral vascular assessment** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Comments:** DVT or Arterial-Catheter Directed Thrombolysis Admission

☑ **Intake and output** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine

☑ **Foley catheter care** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Comments:** To bedside drainage
Question(s):
Orders: Maintain

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

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

☑ **Nursing wound care** **Frequency:** Every 12 hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** Reinforce dressing.
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.

☑ **Assess IV site** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine **Comments:** Assess catheter access site for bleeding/hematoma every 1 hour.

☑ **No injections** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Type of injection: ○ IM ○ SQ

☑ **Notify Vascular Surgery Team - Fibrinogen** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** If Fibrinogen is less than 200, decrease tPA rate by 50%

☑ **Notify Physician for fibrinogen less than 250 Routine** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine

☑ **Notify Physician for all changes in TPA and for any bleeding** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine

○ **McNemera**

☐ **RIGHT - alteplase + heparin**

☑ **RIGHT - alteplase 8 mg in 240 mL NS** **Dose:** 1 mg/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☑ **RIGHT - HEParin 25,000 unit/500 mL (50 unit/mL) in D5W Premix** **Dose:** 250 Units/hr **Route:** intravenous **Frequency:** titrated **Phase of Care:** Post-op
Question(s):
Indication:
Therapeutic Monitoring Target:

☐ **LEFT - alteplase + heparin**

☑ **LEFT - alteplase 8 mg in 240 mL NS** **Dose:** 1 mg/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op

☑ **LEFT - HEParin 25,000 unit in 500 mL in d5w** **Dose:** 250 Units/hr **Route:** intravenous **Frequency:** titrated **Phase of Care:** Post-op
Question(s):
Indication:
Therapeutic Monitoring Target:

☑ **Nursing and Labs**

☑ **Fibrinogen** **Frequency:** Now then every 4 hours **Frequency Limit:** 3 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Partial thromboplastin time, activated** **Frequency:** AM draw **Frequency Limit:** 1 Occurrences **Start Date:** S+1 **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.

☑ **CBC with Platelet and Differential** **Frequency:** Every 12 hours **Frequency Limit:** 2 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Please hold all Anticoagulants while therapy in progress** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine

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

☑ **Strict bed rest** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine

☑ **Peripheral vascular assessment** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Comments:** DVT or Arterial-Catheter Directed Thrombolysis Admission

☑ **Intake and output** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine

☑ **Foley catheter care** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Comments:** To bedside drainage
Question(s):
Orders: Maintain

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

☑ **Nursing wound care** **Frequency:** Every 12 hours **Phase of Care:** Post-op **Priority:** Routine **Comments:** Reinforce dressing.
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.

☑ **Assess IV site** **Frequency:** Every hour **Phase of Care:** Post-op **Priority:** Routine **Comments:** Assess catheter access site for bleeding/hematoma every 1 hour.

☑ **No injections** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine
Question(s):
Type of injection: ○ IM ○ SQ

☑ **Notify Vascular Surgery Team - Fibrinogen** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine **Comments:** If Fibrinogen is less than 200, decrease tPA rate by 50%

☑ **Notify Physician for fibrinogen less than 250 Routine** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine

☑ **Notify Physician for all changes in TPA and for any bleeding** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine

VTE

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

VTE Risk and Prophylaxis Tool (Required)

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

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

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

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

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

- [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):

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

VTE Risk and Prophylaxis Tool

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

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

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

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

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

☑ **Place sequential compression device**

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

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

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

○ **LOW Risk of VTE** (Required)

☑ **Low Risk** (Required)

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

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

☑ **Moderate Risk** (Required)

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

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

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

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

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

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

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

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

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

Patient renal status: @CRCL@

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

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

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **Moderate Risk** (Required)

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

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

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

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

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

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

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

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

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

Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

○ **Not high bleed risk**

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

○ **warfarin (COUMADIN)**

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

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

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

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

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

○ **High Bleed Risk**

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

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

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

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

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

○ **Not high bleed risk**

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

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

○ **warfarin (COUMADIN)**

○ **WITHOUT pharmacy consult Dose:** 1 **Route:** oral **Frequency:** daily at 1700

Question(s):
Indication:
Dose Selection Guidance:

○ **Medications**

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

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

☑ **Mechanical Prophylaxis** (Required)

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

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

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

☑ **High Risk** (Required)

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

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

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

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

Patient renal status: @CRCL@

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

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

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

○ **ENOXAPARIN 30 MG DAILY**

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

○ **ENOXAPARIN SQ DAILY**

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

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

○ **heparin**

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

○ **High Bleed Risk**

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

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:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

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

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

☐ **Partial thromboplastin time** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** 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.

☐ **Lactic acid level** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Process Instructions:
SEPSIS PATIENTS:

FOR ALL SEPSIS OR SUSPECTED SEPSIS CHANGE FREQUENCY TO: NOW THEN EVERY 3 HOURS FOR 3 OCCURRENCES

☐ **Fibrinogen** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Thromboelastograph** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Anticoagulant Therapy: ○ Other
Diagnosis: ○ F.O.R
Fax Number (For TEG Graph Result): ○ NA
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

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

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

☐ **Hepatic function panel** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Laboratory Repeat

☐ **CBC with Platelet and Differential** **Frequency:** Now then every 4 hours **Frequency Limit:** 3 Occurrences **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Arterial blood gas** **Frequency:** Every 4 hours **Frequency Limit:** 3 Occurrences **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Lactate dehydrogenase (LD) isoenzymes** **Frequency:** Every 4 hours **Frequency Limit:** 3 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

☐ **Creatine kinase, total (CPK)** **Frequency:** Every 4 hours **Frequency Limit:** 3 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Troponin T** **Frequency:** Every 4 hours **Frequency Limit:** 3 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **CBC with Platelet and Differential** **Frequency:** Every 6 hours **Frequency Limit:** 3 Occurrences **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Basic metabolic panel** **Frequency:** Every 6 hours **Frequency Limit:** 3 Occurrences **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Arterial blood gas** **Frequency:** Every 6 hours **Frequency Limit:** 3 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Partial thromboplastin time, activated** **Frequency:** Every 6 hours **Frequency Limit:** 3 Occurrences **Start Date:** S **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.

☐ **Prothrombin time with INR** **Frequency:** Every 6 hours **Frequency Limit:** 3 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Fibrinogen** **Frequency:** Every 6 hours **Frequency Limit:** 3 Occurrences **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☐ **Lactic acid level** **Frequency:** Every 6 hours **Frequency Limit:** 3 Occurrences **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Process Instructions:
SEPSIS PATIENTS:

FOR ALL SEPSIS OR SUSPECTED SEPSIS CHANGE FREQUENCY TO: NOW THEN EVERY 3 HOURS FOR 3 OCCURRENCES

☐ **Thromboelastograph** **Frequency:** Every 6 hours **Frequency Limit:** 3 Occurrences **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Anticoagulant Therapy: ○ Other
Diagnosis: ○ F.O.R
Fax Number (For TEG Graph Result): ○ NA
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

Laboratory Tomorrow

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

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

☐ **Comprehensive metabolic panel** **Frequency:** AM draw **Frequency Limit:** 1 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

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

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

Cardiology

Imaging

X-Ray

☐ **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.):

☐ **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.):

Other Studies

Other Diagnostic Studies

☐ **ECG Pre/Post Op** **Frequency:** Once **Phase of Care:** Post-op **Priority:** STAT **Maximum Quantity:** 6
Question(s):
Clinical Indications:
Interpreting Physician:

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:_____