

Acute Stroke Post t-PA

Admit Orders

CHECK BOX TO ACTIVATE ORDER

ADMISSION INFORMATION Ht: _____ Wt: _____	Admit to: <input type="checkbox"/> HOSPITALIST SERVICE and/or <input type="checkbox"/> Dr. _____ Inpatient ICU (See Critical Care Authorization Sheet) Secondary diagnosis: _____ Condition: <input type="checkbox"/> stable <input type="checkbox"/> fair <input type="checkbox"/> guarded <input type="checkbox"/> critical Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____ Code Status: (See Goldenrod) Advance Directives: <input type="checkbox"/> on chart <input type="checkbox"/> completed at office-please call for copy <input type="checkbox"/> unknown
REFERRALS	<input checked="" type="checkbox"/> Notify neurologist of patient admit – Nursing to call @ 0700 on the morning after admit. <input checked="" type="checkbox"/> Stroke Rehab Evaluation <input type="checkbox"/> Dysphagia <input type="checkbox"/> Discharge Planning <input type="checkbox"/> Financial Services <input type="checkbox"/> Wound/Ostomy Care RN <input type="checkbox"/> Social Services <input type="checkbox"/> Other: _____ Integrative Health: <input type="checkbox"/> Integrative Medical Consult <input type="checkbox"/> All OK PRN pt request <input type="checkbox"/> Acupuncture <input type="checkbox"/> Music Care <input type="checkbox"/> Guided Imagery/Hypnosis <input type="checkbox"/> Massage therapy <input type="checkbox"/> Osteopathy
NURSING CARE	VS and neuro assessment every 15 minutes X 2 hours then every 30 minutes X 6 hours then hourly X 16 hours and then per unit policy <input type="checkbox"/> Foley <input type="checkbox"/> I&O <input type="checkbox"/> Weigh daily Activity: <input type="checkbox"/> Bed rest <input type="checkbox"/> BRP <input type="checkbox"/> OOB to chair every _____ <input type="checkbox"/> Ambulate as tolerated <input type="checkbox"/> Notify physician if: HR <60 or >120 ■ SBP <80 or >160 ■ DBP >100 ■ RR <8 ■ Temp >101.5 ■ SpO ₂ <90% ■ Urine Output <20 ml/hr X 2 hours OR <input type="checkbox"/> Notify physician if: ■ HR < _____ or > _____ ■ SBP < _____ or > _____ ■ DBP < _____ or > _____ ■ RR < _____ or > _____ ■ Temp > _____ ■ SpO ₂ < _____% ■ Urine Output < _____ ml/hr <input checked="" type="checkbox"/> Bleeding precautions – no tooth brushing for 24^o Notify physician of signs or symptoms of systemic bleeding or neurological deterioration including but not limited to: <ul style="list-style-type: none"> • Nausea, vomiting, severe new onset headache • Sudden increase in BP (≥40mm Hg) • Worsening neurological status (ie increased weakness, confusion, pupillary dilatation, etc.)
LAB	On admit (if not done in ED): <input type="checkbox"/> CBC <input type="checkbox"/> Manual diff <input type="checkbox"/> CMP <input type="checkbox"/> CPK, Troponin <input type="checkbox"/> Magnesium <input type="checkbox"/> Prottime/INR <input type="checkbox"/> PTT <input type="checkbox"/> Lipid Panel (Fasting) <input type="checkbox"/> ABG <input type="checkbox"/> Other _____ <input type="checkbox"/> AM Labs: CBC, CMP (Fasting), Magnesium
X-RAY	<input type="checkbox"/> CXR portable if not done in ER <input type="checkbox"/> To dept for PA and lateral <input checked="" type="checkbox"/> Bilateral carotid ultrasound/doppler <input checked="" type="checkbox"/> 2D echocardiogram <input type="checkbox"/> Bilateral leg ultrasounds <input type="checkbox"/> MRI brain scan without gadolinium contrast <input type="checkbox"/> Non-contrast CT brain scan <input type="checkbox"/> MR angiogram <input type="checkbox"/> Other: _____ Reason for exams: _____
Prevention of Aspiration	<input type="checkbox"/> NPO (including medications) <input checked="" type="checkbox"/> HOB elevated 45 ^o <input checked="" type="checkbox"/> Swallow Screening by RN today prior to first drink of water. Call physician for diet order if patient passes this test. <input type="checkbox"/> Swallowing evaluation and diet per dysphagia therapist recommendations (patient must be able to maintain alertness for 15 minutes, follow simple commands, and sit at least 60 degrees upright for this evaluation to take place).
DIETARY	<input type="checkbox"/> Begin diet today <input type="checkbox"/> Begin diet tomorrow <input type="checkbox"/> Nutrition Consult <input type="checkbox"/> Mechanical soft <input type="checkbox"/> Pureed <input type="checkbox"/> Thick liquids <input type="checkbox"/> Regular <input type="checkbox"/> Low Na/Cholesterol Other: _____ <input type="checkbox"/> Crush all meds and administer with applesauce or pudding if pt. has passed swallow eval. or cleared by speech. <input type="checkbox"/> TPN per protocol <input type="checkbox"/> Tube feeding (jujueal per protocol)
RESPIRATORY CARE	<input type="checkbox"/> EKG if not done in ER; notify physician of ST-segment elevation or new LBBB <input type="checkbox"/> O ₂ to maintain SpO ₂ ≥ 92%
INFECTION PREVENTION	<input type="checkbox"/> Isolation Precautions—for: _____ MRSA LEGAL REQUIREMENTS: <input checked="" type="checkbox"/> MRSA NARES SCREEN ON <u>ADMIT</u> if: Discharged from an acute care hospital within past 30 days; OR Transferred from a nursing facility; OR Admission to ICU (one screen per hospital stay) <input type="checkbox"/> Positive MRSA History—Do not test. Start Glove Precautions. <input checked="" type="checkbox"/> MRSA NARES SCREEN ON <u>DAY OF DISCHARGE</u> if Palm Drive LOS > 10 days AND patient was in ICU. CULTURES: <input type="checkbox"/> wound <input type="checkbox"/> aspiration closed wound <input type="checkbox"/> sputum (PNA) <input type="checkbox"/> U/A with UTI symptoms/Hx <input type="checkbox"/> Blood DIARRHEA: (3 or more unformed stools in past 24 hours)—NOTIFY I.P. x4386 and send stool for C-Difficile Other etiologies: <input type="checkbox"/> Bacterial (stool culture) <input type="checkbox"/> Norovirus <input type="checkbox"/> Parasites x3 (O&P) rate <input type="checkbox"/> Other: _____

