

General Admit Orders Adult

CHECK BOX TO ACTIVATE ORDER

<p>ADMISSION INFORMATION</p> <p>Ht: _____</p> <p>Wt: _____</p>	<p>Admit to: <input type="checkbox"/> HOSPITALIST SERVICE and/or <input type="checkbox"/> Dr. _____</p> <p><input type="checkbox"/> Med/Surg <input type="checkbox"/> Telemetry (see Tele Orders) <input type="checkbox"/> ICU</p> <p>Diagnosis: _____</p> <p>Secondary Diagnoses: _____</p> <p>Condition: <input type="checkbox"/> stable <input type="checkbox"/> fair <input type="checkbox"/> guarded <input type="checkbox"/> critical</p> <p>Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other _____</p> <p>Code Status: (see Goldenrod)</p> <p>Advance Directives: <input type="checkbox"/> on chart <input type="checkbox"/> completed at office-please call for copy <input type="checkbox"/> unknown</p>
<p>REFERRALS</p>	<p><input type="checkbox"/> Discharge Planning <input type="checkbox"/> Financial Services <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech <input type="checkbox"/> Dysphagia <input type="checkbox"/> Wound/Ostomy Care RN</p> <p><input type="checkbox"/> Social Services <input type="checkbox"/> Other: _____</p> <p>Integrative Health: <input type="checkbox"/> Integrative Medical Consult <input type="checkbox"/> All OK PRN pt request <input type="checkbox"/> Acupuncture</p> <p><input type="checkbox"/> Music Care <input type="checkbox"/> Guided Imagery/Hypnosis <input type="checkbox"/> Massage therapy <input type="checkbox"/> Osteopathy</p>
<p>NURSING CARE</p>	<p>VS: <input type="checkbox"/> Per unit Protocol <input type="checkbox"/> Every _____ hours</p> <p>I&O daily <input type="checkbox"/> weigh daily</p> <p><input type="checkbox"/> Foley catheter—UA dip to Lab with insertion</p> <p><input type="checkbox"/> Turn patient every 2 hours</p> <p>Activity: <input type="checkbox"/> Bed rest <input type="checkbox"/> BSC <input type="checkbox"/> OOB to chair at least _____ daily <input type="checkbox"/> Amb as tol. <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Notify physician if: HR <60 or >120 ■ SBP <80 or >160 ■ DBP >100 ■ RR <8 ■ Temp >101.5</p> <p>■ SpO2 <90% ■ Urine Output <20 ml/hr X 2 hours</p> <p>OR</p> <p><input type="checkbox"/> Notify physician if: ■ HR < _____ or > _____ ■ SBP < _____ or > _____ ■ DBP < _____ or > _____</p> <p>■ RR < _____ or > _____ ■ Temp > _____ ■ SpO2 < _____ % ■ Urine Output < _____ ml/hr</p>
<p>LAB</p>	<p>On Admit: (if not done in ED) <input type="checkbox"/> CBC <input type="checkbox"/> Manual diff <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> UA <input type="checkbox"/> ABG <input type="checkbox"/> PT/PTT</p> <p><input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____</p> <p><input type="checkbox"/> Blood Culture x 2 different sites (collect before antibiotics)</p> <p>AM Labs: _____ Daily Labs: _____</p>
<p>X-RAY</p>	<p><input type="checkbox"/> CXR PA/ Lat <input type="checkbox"/> CXR Portable AP <input type="checkbox"/> Other: _____</p>
<p>DIETARY</p>	<p><input type="checkbox"/> Dietary Consult <input type="checkbox"/> NPO <input type="checkbox"/> Clear Liquids <input type="checkbox"/> Full Liquids <input type="checkbox"/> Regular <input type="checkbox"/> _____ Gm Sodium</p> <p><input type="checkbox"/> _____ Calories ADA <input type="checkbox"/> Encourage fluids <input type="checkbox"/> Other: _____</p>
<p>RESPIRATORY CARE</p>	<p>SpO2 <input type="checkbox"/> every shift <input type="checkbox"/> every am <input type="checkbox"/> with ambulation on room air</p> <p><input type="checkbox"/> EKG; notify physician of ST-segment elevation or new LBBB</p> <p><input type="checkbox"/> O2 via _____ @ _____ LPM and titrate to maintain SpO2 ≥ 92% or _____ %</p> <p><input type="checkbox"/> Suction _____</p> <p><input type="checkbox"/> Incentive Spirometer 5-10 repetitions every 1-2 hours WA</p> <p><input type="checkbox"/> cough and deep breathe every 2 hours WA</p> <p><input type="checkbox"/> Fluticasone/Salmeterol (Advair) _____ mcg/ _____ mcg by DPI, 1 puff BID</p> <p><input type="checkbox"/> Tiotropium (Spiriva) 1 capsule (18mcg) by DPI daily</p> <p><input type="checkbox"/> Albuterol 2.5mg by HHN every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium 0.5mg by HHN 4 times daily PRN SOB wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium/Albuterol (Duoneb) by HHN every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Levalbuterol (Xopenex) 1.25mg by HHN _____ hours PRN SOB, wheezing, or desaturation</p> <p>OR</p> <p><input type="checkbox"/> Albuterol 90mcg by MDI with spacer 2-4 puffs every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium (Atrovent) by MDI with spacer 2-4 puffs 4 times daily PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium/Albuterol (Combivent) by MDI 1-2 puffs every _____ hours PRN SOB, wheezing, or desaturation</p>
<p>IV</p>	<p><input type="checkbox"/> Saline Lock <input type="checkbox"/> _____ to run at _____ ml/hour</p> <p><input type="checkbox"/> PICC consult/protocol</p>
<p>PEPTIC ULCER PROPHYLAXIS</p>	<p><input type="checkbox"/> Famotidine (Pepcid) 20 mg PO / IV BID</p> <p><input type="checkbox"/> Pantoprazole (Protonix) 40mg PO / IV daily</p>
<p>GLYCEMIC CONTROL</p>	<p><input type="checkbox"/> Notify physician if AM fasting blood sugar is > 140</p> <p><input type="checkbox"/> Sliding Scale Insulin (See sliding scale order sheet)</p> <p><input type="checkbox"/> Intensive Insulin Protocol (ICU only – see order sheet)</p>

NOTE: EMPIRIC ANTIBIOTIC GUIDELINES to be attached to this order set.

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ANTIBIOTICS	ANTIBIOTICS MUST BE ORDERED ON "EMPIRIC ANTIBIOTIC GUIDELINES" ORDER SET		
VTE Prophylaxis	PATIENT CATEGORY / RISK FACTORS	RISK	PROPHYLAXIS METHOD
	Patient is < 40 years old & no additional risk factor (See High Risk below)	LOW	<input type="checkbox"/> No specific measures; early ambulation
	Patient 40-60 years with limited mobility and no additional risk factor (see High risk below)	MOD	<input type="checkbox"/> Sequential compression device OR <input type="checkbox"/> TED hose OR <input type="checkbox"/> Enoxaparin 40mg subQ daily x 10 days OR <input type="checkbox"/> Heparin 5,000 units subQ every 8 hours x 10 days
	Patient >60 yrs or any risk factor such as: CHF, MI, resp. failure, trauma (major or lower extremity), cancer, infection, restricted mobility, ICU admit, obesity, surgery, varicose veins, prior DVT/PE, chronic lung disease, inflammatory bowel disease, smoking, HRT use, pregnancy current or recent.	HIGH	<input type="checkbox"/> Sequential compression device OR <input type="checkbox"/> TED hose PLUS _____ <input type="checkbox"/> Enoxaparin 40mg subQ daily x 10 days OR <input type="checkbox"/> Heparin 5,000 units subQ every 8 hours x 10 days
	Contraindications to anticoagulation therapy <ul style="list-style-type: none"> • No mechanical prophylaxis due to: <input type="checkbox"/> bilateral amputee <input type="checkbox"/> lower extremity trauma • No anticoagulation at this time due to: <input type="checkbox"/> pharmacological VTE prophylaxis: <input type="checkbox"/> platelet count <100,000/mm <input type="checkbox"/> on warfarin prior to admit <input type="checkbox"/> active bleeding (GI bleed) <input type="checkbox"/> cerebral hemorrhage <input type="checkbox"/> CVA <input type="checkbox"/> retroperitoneal bleeding <input type="checkbox"/> bleeding risk <input type="checkbox"/> HIT <input type="checkbox"/> lumbar puncture within 24 hrs <input type="checkbox"/> epidural cath within 24 hours <input type="checkbox"/> hypersensitivity to Heparin or Enoxaparin. <input type="checkbox"/> patient refusal <input type="checkbox"/> other: _____ 	E X C E P T I O N	<input type="checkbox"/> Sequential compression device OR <input type="checkbox"/> TED hose
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: _____		
PAIN	<input type="checkbox"/> Ketorolac (Toradol) _____mg IV every 6 hours x ____ doses OR <input type="checkbox"/> _____mg IV every 6 hours PRN x ____ doses <input type="checkbox"/> PCA—See "PCA Physician Order Form" (Pts may receive only those meds ordered on form. Pain, sedation, and nausea meds checked below may be initiated after PCA orders D/C'd) For IV pain control: (do not give any PO pain meds while patient receiving IV pain meds) <input type="checkbox"/> Morphine Sulfate _____mg IV every 15 min PRN pain <input type="checkbox"/> Hydromorphone (Dilaudid) _____mg IV every hour PRN severe pain (max = _____mg in 4 hours) For PO pain control: (may give IV pain med only if ordered for breakthrough pain) <input type="checkbox"/> Oxycodone/Acetaminophen (Percocet) 5/325mg 1 tab PO every 3 hours PRN mild to moderate pain (< 5/10) <input type="checkbox"/> Oxycodone/Acetaminophen (Percocet) 5/325mg 2 tabs PO every 3 hours PRN moderate to severe pain (≥ 5/10) <input type="checkbox"/> Hydrocodone/Acetaminophen (Norco) 5/325mg 1 tab PO every 4 hours PRN mild to moderate pain (< 5/10) <input type="checkbox"/> Hydrocodone/Acetaminophen (Norco) 5/325mg 2 tabs PO every 4 hours PRN moderate to severe pain (≥ 5/10) <input type="checkbox"/> Morphine Sulfate _____mg IV every 1 hour PRN for breakthrough pain <input type="checkbox"/> Hydromorphone (Dilaudid) _____mg IV every 1 hour PRN for breakthrough pain		

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NAUSEA/ VOMITING	<input type="checkbox"/> Prochlorperazine (Compazine) 10mg PO every 6 hrs or 25mg supp every 12 hrs PRN nausea <input type="checkbox"/> Dolasetron (Anzemet) 12.5mg IV every 6 hrs PRN nausea or vomiting <input type="checkbox"/> Metoclopramide (Reglan) 10mg IV every 6 hrs PRN nausea or vomiting <input type="checkbox"/> Ondansetron (Zofran) 4mg IV every 6 hrs PRN nausea or vomiting
BOWEL CARE	<input type="checkbox"/> Follow PDH "Bowel Care Protocol" Docusate Sodium (DSS) 250 mg PO daily Bisacodyl (Dulcolax) Supp 10 mg PR daily PRN constipation MOM 30 ml PO daily PRN constipation Fleets Enema daily PRN constipation
ANXIETY	<input type="checkbox"/> Alprazolam (Xanax) 0.25 mg PO every 6 hours PRN anxiety or <input type="checkbox"/> Lorazepam (Ativan) _____ mg IV / PO (circle one) every _____ hrs PRN anxiety
SLEEP	<input type="checkbox"/> Temazepam (Restoril) PO q HS PRN insomnia MR X 1 in 1 hour <input type="checkbox"/> 7.5 mg (rec. for >65 yrs) <input type="checkbox"/> 15 mg (for <65 yrs) OR <input type="checkbox"/> Zolpidem (Ambien) 5 mg PO HS PRN sleep MR X 1
VACCINES	Influenza vaccine: per Influenza Vaccination Screening & Administration Protocol Pneumonia vaccine: per Pneumococcal Vaccination Screening & Administration Protocol
OTHER MEDICATIONS	<input type="checkbox"/> Multivitamin with minerals 1 tab PO daily <input type="checkbox"/> PPD <input type="checkbox"/> PPD with Candida control (HIV expected) <input type="checkbox"/> Acetaminophen (Tylenol) 650mg PO/ Supp every 4 hours PRN temp >100°F or mild pain (max daily dose = 4 gms) <input type="checkbox"/> Magnesium Hydroxide (Mylanta) 30 ml PO every 4 hours PRN indigestion <input type="checkbox"/> Nicotine Patch: <input type="checkbox"/> 7 mg daily <input type="checkbox"/> 14 mg daily <input type="checkbox"/> 21 mg daily
OTHER ORDERS	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Physician Signature: _____ Date: _____ Time: _____

Transcriber Signature: _____ Date: _____ Time: _____

NOTE: EMPIRIC ANTIBIOTIC GUIDELINES to be attached to this order set.