(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Order Set Directions:
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Diagnosis: _____

Allergies with reaction type:_____

Admission Basic

Version 5 11/01/17

- This order set must be used in conjunction with a diagnosis/procedure based order set

Patient Placement

Patient Status

- If the physician cannot anticipate that the duration of episode of care for the patient will cross two midnights, the patient should continue to be treated as an outpatient (observation services) and should be admitted if or when additional information suggests or the physician anticipates that the duration of the episode of care will cross a second midnight.
  - ☐ Admit to inpatient: **I certify that:
    Inpatient services are reasonable and necessary and ordered in accordance with Medicare regulations.
    Services ordered are appropriate for the inpatient setting.
    It is anticipated that the medically necessary care of the patient will cross at least 2 midnights.
    The diagnosis included in this order is the reason for inpatient services and is outlined further in the history and physical and subsequent progress notes.
    The need for post hospital care will be determined based upon the patient's evolving clinical condition and needs.
  - ☐ Observation services
    Observation reason:
    Patient may require further evaluation to determine whether an inpatient admission is medically necessary [ ] Yes [ ] No
    Patient's symptoms are anticipated to improve quickly with medical management [ ] Yes [ ] No
  - ☐ Comfort care only [ ] Yes [ ] No
  - ☐ Placement for Post Procedure/Operative (SDC Status Outpatient Less than 23 hour stay)
  - ☐ Attending Provider: _____

Preferred Location/Unit

- ☐ ICU
- ☐ PCVU
- ☐ General Medical
- ☐ Surgical
- ☐ Ortho/Neuro
- ☐ Oncology
- ☐ Med Safe

Code Status:

- ☐ Full Code ☐ DNR

Limited DNR Status

- ☐ No intubation, mechanical ventilation
- ☐ No chest compressions
- ☐ No emergency medications or fluid
- ☐ No defibrillation, cardioversion
- ☐ No _____

Activity

- ☐ Ambulate Ad Lib
- ☐ Ambulate TID
- ☐ Out of bed with assistance
- ☐ Up to chair
- ☐ Other:_____
- ☐ Bed rest with bathroom privileges
- ☐ Bed rest with bedside commode
- ☐ Bed rest

Nursing Orders

- ☑ Vital signs per unit standard ☐ Vital signs non unit standard _____
- ☐ Vital signs, orthostatic once a day
- ☐ Point of Care Capillary Blood Glucose 4 times a day, before meals and at bedtime
- ☐ Medical Telemetry: Patient may be off telemetry for showering or transport for diagnostic tests [ ] Yes [ ] No
- ☑ Intake and output per unit standard ☐ Intake and output STRICT ☐ Intake and output voided
- ☐ Measure weight once a day
- ☑ Initiate MRSA Testing and Treatment Protocol

Initials_____

(place patient label here)

Patient Name: _____

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BENEFIS HEALTH SYSTEM
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PROVIDER ORDERS

☑ Initiate Carrier Fluid Protocol IF NO Maintenance IV currently running
☐ Other:_____

Respiratory

☐ Pulse oximetry continuous

Oxygen administration

☐ Nasal Cannula at ____ Lpm and titrate to maintain Oxygen saturation greater than 90%
☐ Nasal Cannula RN/RT to determine flow and titrate to maintain Oxygen saturation greater than 90%
☐ Other: _____ at _____ Lpm

☐ Continuous positive airway pressure (CPAP), patient may use own- as per home settings
☐ Other:_____

Diet

☐ Regular Diet
☐ Heart Healthy Diet
☐ Controlled Carbohydrate Diet
☐ Full Liquid Diet
☐ Clear Liquid Diet
☐ NPO
☐ NPO at _____
☐ Advance diet as tolerated to goal diet of: _____
☐ Other Diet or Diet Modifiers:_____

IV Placement

☐ Peripheral IV insert/maintain
☐ Saline lock with saline flush BID

IV Fluids - Maintenance infusion

IV Fluid-Maintenance

☐ Fluid: _____
Additive: _____
Rate: _____
Duration (If rate not selected): _____

Laboratory

Admission labs or labs to be obtained now:

- Please order Respiratory Viral Panel for patients being admitted for acute or suspected respiratory tract infections (pneumonia, bronchitis, viral respiratory infections or fever >100.5 with cough with unknown cause)
  - ☐ Respiratory Viral Panel by PCR (RT to collect)
  - ☐ Other labs:_____

Consult Provider

- Provider to provider notification preferred.
  - ☐ Consult other provider _____ regarding _____
    Does nursing need to contact consulted provider? [ ] Yes [ ] No
  - ☐ Consult Hospitalist

Consult Department

☐ Consult Care Coordination Reason for consult: _____
☐ PT Physical Therapy Eval & Treat Reason for consult: _____
☐ OT Occupational Therapy Eval & Treat Reason for consult: _____
☐ ST Speech Therapy Eval & Treat Reason for consult: _____
☐ Consult Wound/Ostomy Nurse Reason for consult: _____
Initiate Wound Care Protocol [ ] Yes [ ] No

Initials_____

(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
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Diagnosis: _____ Allergies: _____

VTE Prophylaxis

Step 1: VTE Risk Assessment: SELECT ONE RISK CATEGORY

☐ **LOW RISK- FEW PATIENTS FALL IN THIS CATEGORY** (Includes ambulatory patients WITHOUT additional VTE risk factors [see Appendix 1 for risk factors]) No specific measure required, early ambulation

- *Order for all **LOW** risk patients **IF** not already ordered.*
  - ☐ Ambulate 3 times a day

☐ **MODERATE RISK- ANY PATIENT NOT IN LOW RISK OR HIGH RISK CATEGORY-MOST PATIENTS FALL IN THIS CATEGORY** (Patients with one or more VTE risk factors)

☐ **HIGH RISK- ANY PATIENT NOT IN LOW OR MODERATE RISK CATEGORY** (Includes: Elective major lower extremity arthroplasty, hip, pelvic or surgery, lower extremity fracture, acute spinal cord injury with paresis, multiple major trauma, abdominal or pelvic surgery for cancer)

Step 2: Order Prophylaxis

☐ Prophylaxis already addressed post-operatively- See post-op orders

➢ *Pharmacological VTE Prophylaxis*

- *Order for **MODERATE** and **HIGH** risk patients unless contraindicated*

☐ No pharmacological prophylaxis due to the following contraindications: SELECT ALL THAT APPLY

CONTRAINDICATIONS		
Absolute	**Relative**	
☐ Active hemorrhage or high risk for hemorrhage	☐ Craniotomy in last 2 weeks	☐ Active intracranial lesions/ neoplasms
☐ Severe trauma to head or spinal cord WITH hemorrhage in last 4 wks	☐ Intracranial hemorrhage in 12 mos.	☐ Hypertensive emergency
	☐ Intraocular surgery in last 2 wks	☐ Post-op bleeding concerns
	☐ GI, GU hemorrhage in last 30 days	☐ Scheduled to return to OR in the next 24 hrs
	☐ Thrombocytopenia (< 50,000)	☐ Epidural catheters or spinal block
	☐ Coagulopathy (PT > 18 sec)	☐ End stage liver disease
OTHER:		

Medications

enoxaparin (LOVENOX)
- ☐ 40 milligram subcutaneously once a day
- ☐ 30 milligram subcutaneously once a day for impaired renal function- GFR less than 30 mL/min

heparin
- ☐ 5,000 unit subcutaneously every 12 hours
- ☐ 5,000 unit subcutaneously every 8 hours

● Select fondaparinux (ARIXTRA) ONLY IF suspected or known history of immune-mediated HIT OR allergy to enoxaparin (LOVENOX)

fondaparinux (ARIXTRA)
- ☐ 2.5 milligram subcutaneously once a day DO NOT USE if GFR less than 30mL/min

☐ Other Medication: _____

Laboratory

☑ CBC without differential every 3 days IF pharmacological prophylaxis is ordered

➢ *Mechanical VTE Prophylaxis*

- *Order for **HIGH** risk patients and **MODERATE** risk patients without pharmacological prophylaxis*

☐ No mechanical prophylaxis due to the following contraindications: SELECT ALL THAT APPLY

Mechanical Contraindications
☐ Bilateral lower extremity amputee ☐ Bilateral lower extremity trauma ☐ Other:_____

Initi

Intermittent pneumatic compression
- ☐ Sequential compression device (SCD)
- ☐ Arterial venous impulses (AVI)

Apply anti-embolic stockings (graduated)
- ☐ knee high
- ☐ thigh high

(place patient label here)

Patient Name: _____

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Provider Signature:_____Date:_____Time:_____