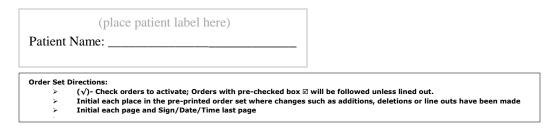
(place patient label here) Patient Name: Order Set Directions: > (v)- Check orders to activate; Orders with pre-checker > Initial each place in the pre-printed order set where checker > Initial each page and Sign/Date/Time last page	l box ☑ will be followed unless lined out. anges such as additions, deletions or line outs have been made	Benefis HEALTH SYSTEM Benefis HOSPITALS PROVIDER ORDERS
Allergies with reaction type:		
Patient Placement Patient Status If the physician cannot anticipate to the patient should continue to be to when additional information suggest cross a second midnight. Admit to inpatient: **I certify the Inpatient services are reasonabeed Services ordered are appropriated It is anticipated that the medicated The diagnosis included in this of and physical and subsequent profit The need for post hospital care needs. Observation services Observation reason: Patient may require further evant necessary [] Yes [] No Patient's symptoms are anticipated Comfort care only [] Yes [] No Placement for Post Procedure/Odditional Attending Provider:	le and necessary and ordered in accordance we for the inpatient setting. Ally necessary care of the patient will cross at I rder is the reason for inpatient services and is ogress notes. Will be determined based upon the patient's end is determined based upon the patient's end in the determine whether an inpatient admitted to improve quickly with medical managements to perative (SDC Status Outpatient Less than 23	ient will cross two midnights, and should be admitted if or on of the episode of care will with Medicare regulations. least 2 midnights. outlined further in the history evolving clinical condition and mission is medically nent [] Yes [] No
□ Vital signs, orthostatic once a day□ Point of Care Capillary Blood Gluco□ Medical Telemetry: Patient may be	Code Status: □ Full Code □ DNR Limited DNR Status □ No intubation, mechani □ No chest compressions □ No emergency medicat □ No defibrillation, cardic □ No □ Bed rest with bathroom privileges □ Bed rest with bedside commode □ Bed rest □ Vital signs non unit standard □ se 4 times a day, before meals and at bedtimes off telemetry for showering or transport for day of the lintake and output STRICT □ Intake	e liagnostic tests [] Yes [] No

Initials_____





☑ 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 Diet □ Regular Diet □ Clear Liquid Diet Heart Healthy Diet □ NPO □ Controlled Carbohydrate Diet □ NPO at □ Full Liquid Diet □ 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: _____ 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:

Initials_____

□ PT Physical Therapy Eval & Treat Reason for consult:

Initiate Wound Care Protocol [] Yes [] No

□ OT Occupational Therapy Eval & Treat Reason for consult: _____

□ Consult Wound/Ostomy Nurse Reason for consult: ______

□ ST Speech Therapy Eval & Treat Reason for consult: _____

(place patient label here	2)			Benefis health system Benefis Hospitals
Patient Name:				
Order Set Directions:	et where changes such as		ave been made	PROVIDER ORDERS
Diagnosis:		Allergies:		
/TE Prophylaxis				
Appendix 1 for risk factors]) No sp ● Order for all LOW risk patients I. □ Ambulate 3 times a day □ MODERATE RISK- ANY PATIEN CATEGORY (Patients with one or mo □ HIGH RISK- ANY PATIENT NO	ecific measure rec F not already orde IT NOT IN LOW F ore VTE risk factors) T IN LOW OR MO	uired, early ambulation red. RISK OR HIGH RISK CA DERATE RISK CATEGO	ATEGORY-M DRY (Includes	
Step 2: Order Prophylaxis □ Prophylaxis already ad > Pharmacological VTE Prophyla • Order for MODERATE and HIGH	axis risk patients unles	ss contraindicated		
☐ No pharmacological prophylaxi		owing contraindication NTRAINDICATIONS	ns: SELECT	ALL THAT APPLY
Absolute	Relative	NIKAINDICATIONS		
☐ Active hemorrhage or high risk for hemorrhage ☐ Severe trauma to head or spinal cord WITH hemorrhage in last 4 wks	☐ Craniotomy ☐ Intracranial ☐ Intraocular s ☐ GI, GU hemo ☐ Thrombocyto	in last 2 weeks hemorrhage in 12 mos. surgery in last 2 wks orrhage in last 30 days openia (< 50,000) y (PT > 18 sec)	☐ Hyperte ☐ Post-op ☐ Schedu ☐ Epidura	intracranial lesions/ neoplasms ensive emergency b bleeding concerns led to return to OR in the next 24 hrs al catheters or spinal block ige liver disease
OTHER:				
Medications enoxaparin (LOVENOX) □ 40 milligram subcutaneously of heparin □ 5,000 unit subcutaneously ever	nce a day for impa ry 12 hours ry 8 hours NLY IF suspected sly once a day D	or known history of i	mmune-medi s than 30m	ated HIT OR allergy to enoxaparin
> Mechanical VTE Prophylaxis				

Initi Intermittent pneumatic compression

Mechanical Contraindications

 \square Sequential compression device (SCD)

☐ Arterial venous impulses (AVI)

Apply anti-embolic stockings (graduated)

□ Other:_

□ knee high

□ thigh high

_

Order for HIGH risk patients and MODERATE risk patients without pharmacological prophylaxis
 No mechanical prophylaxis due to the following contraindications: SELECT ALL THAT APPLY

 $\ \square$ Bilateral lower extremity amputee $\ \square$ Bilateral lower extremity trauma

(place patient label here)
Patient Name:

BENEFIS HEALTH SYSTEM

PROVIDER ORDERS

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