(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Order Set Directions:
- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: _____

Allergies with reaction type:_____

SO ED Suspected Sepsis — Version 2 4/2/19

- Activate this Standing Order (SO) by selecting the appropriate provider and using the "Standing Order" order source.

Adult with Suspected or Documented Source of Infection AND HR > 90 AND Temp > 100.4 F WITH RR > 20

Nursing Orders

☑ Cardiac Monitoring
☑ Pulse oximetry continuous
☑ Oxygen Delivery RN/RT to Determine Titrate to maintain Oxygen saturation greater than 92%

IV/ Line Insert and/or Maintain

☑ Peripheral IV insert/maintain

IV Fluids - Volume Bolus

30 mL/kg bolus (Edit volume and rate)

Sodium Chloride 0.9% IV
☐ _____ milliliter 30 mL/kg BOLUS intravenously WIDE OPEN RATE

Medications

ondansetron (ZOFRAN)
☑ 4 milligram orally once as needed for nausea/vomiting

Select ONE:

acetaminophen (TYLENOL)
☐ 650 milligram tablet orally once if not allergic
☐ 650 milligram suppository rectally once if not allergic

Laboratory

☑ CBC/AUTO DIFF
☑ COMPREHENSIVE METABOLIC PANEL
☑ MAGNESIUM LEVEL, PLASMA
☑ PHOSPHORUS LEVEL, PLASMA
☑ DIC SCREEN
☑ LACTIC ACID, PLASMA every 2 hours x 3
☑ TROPONIN I
☑ PROCALCITONIN
☑ Blood gas, arterial
☑ BLOOD CULTURE Quantity: 2; Additional Instructions to Phlebotomist: From 2 different sites, 5 minutes apart
☑ CULTURE, URINE
☑ UA WITH MICROSCOPY
☑ TYPE AND SCREEN

IF indicated Select:

☐ CULTURE, SPUTUM AND GRAM ST
☐ CULTURE, WOUND AND GRAM STAIN [RB]

IF Female of Menstruating Age and No Hysterectomy Select:

☐ PREGNANCY TEST, SERUM

IF symptoms of hepatic encephalopathy Select:

☐ AMMONIA, PLASMA

Radiology and Diagnostic Tests

ED ECG (ED Provider Only)
☑ stat Reason for exam: _____

XR Chest Single , portable,
☑ stat Reason for exam: _____

Provider Signature:_____Date:_____Time:_____