(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:_____

ICU Admission Basic

Version 2 Approved 4/10/2017

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.
Diagnosis: _____

☐ Observation services (Condition can be evaluated/treated/improved within 2 midnights or additional time is needed to determine if inpatient admission is medically necessary)

☐ Attending Provider: _____

Preferred Location/Unit

☑ ICU

Comfort care only [ ] Yes [ ] No

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

☐ Up ad lib
☐ Up with assist
☐ Up to chair
☐ Bed rest with bathroom privileges
☐ Bed rest with bedside commode
☐ Bed rest
☐ PT- ICU mobility

Initials_____

(place patient label here)

Patient Name: _____

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**

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Nursing Orders

☑ Initiate MRSA Testing and Treatment Protocol
☑ Vital signs per unit standard ☐ Vital signs non unit standard _____
☑ Intake and output per unit standard
☑ Daily weight
☑ Point of Care Capillary Blood Glucose 4 times a day, before meals and at bedtime Or every 6 hours IF NPO
☐ Foley Catheter
Nasogastric/orogastric tube insertion/management
☐ low intermittent suction ☐ continuous suction ☐ no suction/ gravity
☐ Feeding tube insertion/management (DOBHOFF)

Respiratory

☐ Oxygen Delivery RN/RT to Determine to maintain Oxygen saturation greater than 94%
Oxygen administration
☐ Nasal Cannula at ____ Lpm and titrate to maintain Oxygen saturation greater than 90%
☐ Other: _____ at _____ Lpm
☐ Bilevel positive airway pressure RT to optimize setting
☐ Continuous positive airway pressure (CPAP) , patient my use own- as per home settings
For ventilator orders- Select Ventilator management or ARDS net protocol order sets

Diet

☐ Regular Diet ☐ Full Liquid Diet
☐ Heart Healthy Diet ☐ Clear Liquid Diet
☐ Controlled Carbohydrate Diet ☐ NPO Diet
☐ Advance diet as tolerated to goal diet of: _____
NPO at
☐ Time to Start NPO:_____ ☐ Strict ☐ With Ice Chips ☐ With Sips
☐ Except Meds
☐ Other:_____

IV/ Line Placement

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

IV Fluids - Maintenance Generic Fluid

Select this fluid for IV solution not listed above
IV Fluid-Maintenance
☐ Fluid: _____
Additive: _____
Rate: _____
Duration (If rate not selected): _____

Initials_____

(place patient label here)

Patient Name: _____

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**

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Medications

Analgesics: Non-opioids

acetaminophen (TYLENOL)

- ☐ 650 milligram by nasogastric tube every 4 hours as needed for mild-to-moderate pain or fever greater than 101 F (38.3 C)
- ☐ 650 milligram orally every 4 hours as needed for mild-to-moderate pain or fever greater than 101 F (38.3 C)
- ☐ 650 milligram rectally every 4 hours as needed for mild-to-moderate pain or fever greater than 101 F (38.3 C)

Antibacterial Prophylaxis

mupirocin (BACTROBAN) 2% nasal ointment

- ☑ 0.5 gram in each nostril 2 times a day for 5 days = 10 total doses

Stress Ulcer Prophylaxis Agents: Histamine-2 Receptor Antagonists

famotidine (PEPCID)

- ☐ 20 milligram orally 2 times a day
- ☐ 20 milligram by nasogastric tube 2 times a day
- ☐ 20 milligram intravenously every 12 hours

pantoprazole (PROTONIX)

- ☐ 40 milligram orally once a day H-2 Antagonists preferred if possible
- ☐ 40 milligram by nasogastric tube once a day H-2 Antagonists preferred if possible
- ☐ 40 milligram intravenously every 24 hours H-2 Antagonists preferred if possible

Laxatives: Stool Softeners

docusate sodium (COLACE)

- ☐ 100 milligram orally or by nasogastric tube 2 times a day

senna 8.8 mg/5 mL syrup (SENOKOT)

- ☐ 5 milliliter by nasogastric tube once a day, at bedtime

senna 8.6 mg oral tablet (SENOKOT)

- ☐ 1 tablet orally once a day, at bedtime

Ophthalmic Care

ARTIFICIAL TEARS EYE DROPS

- ☐ 1 drop in each eye every 4 hours as needed for dry eyes

ARTIFICIAL TEARS EYE OINTMENT

- ☐ 0.5 inch in each eye every 4 hours as needed for dry eyes

Laboratory

Admission labs or labs to be obtained now: (IF not done already in ER)

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)
- ☑ MRSA by PCR

Initials_____

(place patient label here)

Patient Name: _____

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**

BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

Consult Provider

Provider to provider notification preferred.

☐ Consult other provider _____ regarding _____ Does nursing need to contact consulted provider? [ ] Yes [ ] No

Consult Department

☐ Consult Care Coordination Reason for consult: _____
☐ Consult Dietitian Reason for consult: _____
☐ PT Physical Therapy Eval & Treat Reason for consult: Critical Care Mobility Program
☐ ST Speech Therapy Eval & Treat Reason for consult: _____
☐ OT Occupational 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
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**

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:_____

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

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

Provider Signature:_____Date:_____Time:_____