

(place patient label here)

Patient Name: \_\_\_\_\_



**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 Comprehensive  
Patient Placement**

**Version 3 4/10/17**

***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)

Comfort care only [ ] Yes [ ] No

Attending Provider: \_\_\_\_\_

***Preferred Location/Unit***

ICU

***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: \_\_\_\_\_



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

**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
- Verify that cultures have been obtained before starting antibiotics
- Point of Care Capillary Blood Glucose 4 times a day, before meals and at bedtime Or every 6 hours
- Foley Catheter, if NPO
- Nasogastric/orogastric tube insert/maintain
  - low intermittent suction
  - continuous suction
  - no suction/ gravity
- Feeding tube (DOBHOFF) insert/maintain

**Respiratory**

For ventilator orders- Select Ventilator Bundle Order set

- 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
- BiPAP
  - May use home equipment and settings [ ] Yes [ ] No
  - Frequency \_\_\_\_\_
  - Duration \_\_\_\_\_
  - IPAP \_\_\_\_\_
  - EPAP \_\_\_\_\_
  - Additional instructions \_\_\_\_\_
- CPAP
  - May use home equipment and settings [ ] Yes [ ] No
  - Frequency \_\_\_\_\_
  - Duration \_\_\_\_\_
  - Additional instructions \_\_\_\_\_

**Diet**

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

Initials \_\_\_\_\_

(place patient label here)

Patient Name: \_\_\_\_\_



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

**IV/ Line Insert and/or Maintain**

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

**IV Fluids - Generic Volume Bolus**

IV Fluid-Bolus

- Fluid: \_\_\_\_\_  
Volume to Infuse: \_\_\_\_\_  
Additive: \_\_\_\_\_  
Rate: \_\_\_\_\_  
Duration (If rate not selected): \_\_\_\_\_

**IV Fluids - Maintenance Specific Fluid**

Sodium Chloride 0.9% IV

- \_\_\_\_\_ milliliter/hour continuous intravenous infusion

Dextrose 5% and 0.45% Sodium Chloride IV

- \_\_\_\_\_ milliliter/hour continuous intravenous infusion

Dextrose 5% and 0.9% Sodium Chloride IV

- \_\_\_\_\_ milliliter/hour continuous intravenous infusion

sodium chloride 0.9% with potassium chloride 20 mEq/L IV (PREMIX)

- \_\_\_\_\_ milliliter/hour continuous intravenous infusion

D5-0.45% Sodium Chloride with Potassium Chloride 20 mEq/L IV (PREMIX)

- \_\_\_\_\_ milliliter/hour continuous intravenous infusion

**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): \_\_\_\_\_

**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

Initials \_\_\_\_\_

(place patient label here)

Patient Name: \_\_\_\_\_



**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

**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 by nasogastric tube 2 times a day
- 100 milligram orally 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

**Vasoactive Agents Continuous Infusion**

DOBUTamine (DOBUTREX) [500 milligrams/ 250 milliliters D5W]

- 2.5-10 microgram/kilogram per minute continuous intravenous infusion : titrate to keep ScvO greater than 70%, maintaining SBP greater than 90 mmHg and Heart Rate less than 140 beats per minute

DOPamine in D5W 400 mg/250 mL (1,600 mcg/mL) IV

- 5 microgram/kilogram per minute continuous intravenous infusion : titrate to keep SPB greater than or equal to 90mmHg and MAP greater than or equal to 65 mmHg

norepinephrine bitartrate in normal saline 4 mg/250 mL IV (LEVOPHED)

- 1-30 microgram/minute continuous intravenous infusion : titrate to keep SBP greater than 90 mmHg and MAP greater than or equal to 65 mmHg

phenylephrine in NS (preserv free) 20 mg/250 mL (0.08 mg/mL) IV (NEO-SYNEPHRINE)

- 20 - 200 microgram/minute continuous intravenous infusion titrate to keep SBP greater than 90 mmHg and MAP greater than or equal to 65 mmHg

vasopressin (PITRESSIN)[100 unit/250 milliliter NS]

- 0.01-0.04 unit/minute continuous intravenous infusion titrate to keep MAP greater than 80 mmHg

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

**PROVIDER ORDERS**

**Bronchodilators**

**Nebulized Agents**

albuterol 2.5 mg/3 mL (0.083 %) solution for nebulization (VENTOLIN)

- 2.5 milligram by nebulizer every 4 hours
- 2.5 milligram by nebulizer every 2 hours as needed for shortness of breath or wheezing

albuterol-ipratropium 2.5 mg-0.5 mg/3 mL soln for inhalation (DUONEB)

- 3 milliliter by nebulizer every 4 hours
- 3 milliliter by nebulizer every 4 hours, while awake

**Inhalation Agents**

albuterol 90 microgram/inhalation aerosol inhaler

- 6 puff inhaled every 4 hours
- 6 puff inhaled every 2 hours as needed for respiratory distress

ipratropium 17 mcg/actuation aerosol inhaler (ATROVENT)

- 6 puff inhaled every 4 hours
- 6 puff inhaled every 2 hours as needed for respiratory distress

**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
- CBC/AUTO DIFF
- COMPREHENSIVE METABOLIC PANEL
- MAGNESIUM LEVEL, PLASMA
- PHOSPHORUS LEVEL, PLASMA
- BASIC METABOLIC PANEL
- LACTIC ACID. PLASMA
- TROPONIN I
- Blood gas study, Arterial
- PT (PROTIME AND INR)
- PTT
- DIC SCREEN

BLOOD CULTURE, from two different sites five minutes apart

- stat
- CULTURE, SPUTUM AND GRAM ST
- RESPIRATORY VIRAL PANEL BY PCR
- UA WITH MICROSCOPY
- UA W/MICROSCOPY, CULT IF INDIC
- CULTURE, URINE
- C DIFFICILE TOXIN BY PCR
- OSMOLALITY, SERUM
- URINE POTASSIUM RANDOM

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

**PROVIDER ORDERS**

- URINE SODIUM RANDOM
- URINE CHLORIDE RANDOM
- URINE ANTIGEN, STREP PNEUMONIA
- URINE ANTIGEN, LEGIONELLA
- Other: \_\_\_\_\_

**Blood Bank**

For transfusion orders please select the transfusion order set

- TYPE AND SCREEN

**Morning Draw:**

- CBC/AUTO DIFF
- COMPREHENSIVE METABOLIC PANEL
- MAGNESIUM LEVEL, PLASMA
- PHOSPHORUS LEVEL, PLASMA
- PT (PROTIME AND INR)
- PTT
- Blood gas study, Arterial
- BASIC METABOLIC PANEL
- UA WITH MICROSCOPY

**Radiology and Diagnostic Tests**

XR Chest Single ,portable

- routine now Reason for exam: \_\_\_\_\_
- routine in AM Reason for exam: \_\_\_\_\_

XR Chest PA and Lateral

- routine now Reason for exam: \_\_\_\_\_
- routine in AM Reason for exam: \_\_\_\_\_

ECG

- stat Reason for exam: \_\_\_\_\_
- routine Reason for exam: \_\_\_\_\_

ECHO, Transthoracic Complete

- stat ICD 9 Indications: \_\_\_\_\_ Contrast? [ ] Yes [ ] No  
Agitated Saline (Bubble Study) [ ] Yes [ ] No Additional Instructions: \_\_\_\_\_
- routine ICD 9 Indications: \_\_\_\_\_ Contrast? [ ] Yes [ ] No  
Agitated Saline (Bubble Study) [ ] Yes [ ] No Additional Instructions: \_\_\_\_\_

ECHO, Transthoracic Limited

- stat ICD 9 Indications: \_\_\_\_\_ Area of Focus: \_\_\_\_\_  
Additional Instructions: \_\_\_\_\_
- routine ICD 9 Indications: \_\_\_\_\_ Area of Focus: \_\_\_\_\_  
Additional Instructions: \_\_\_\_\_

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

**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: \_\_\_\_\_



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

- Active hemorrhage or high risk for hemorrhage
- Severe trauma to head or spinal cord WITH hemorrhage in last 4 wks

Relative

- Craniotomy in last 2 weeks
- Intracranial hemorrhage in 12 mos.
- Intraocular surgery in last 2 wks
- GI, GU hemorrhage in last 30 days
- Thrombocytopenia (< 50,000)
- Coagulopathy (PT > 18 sec)
- Active intracranial lesions/ neoplasms
- Hypertensive emergency
- Post-op bleeding concerns
- Scheduled to return to OR in the next 24 hrs
- Epidural catheters or spinal block
- 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: \_\_\_\_\_