(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.
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Diagnosis: _____

Allergies with reaction type:_____

Trauma Admission

Version 1 12/10/14

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 (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
- ☐ PCU
- ☐ CVU
- ☐ General Medical
- ☐ Surgical
- ☐ Ortho/Neuro
- ☐ Oncology

Code Status:
- ☐ Full Code
- ☐ DNR

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

Injuries: _____

VS: _____

Check box if ordered:
SCD, AVI, Thigh TEDS, Knee TEDs

_____Foley _____

____ NG _____

____ IS _____ Cough & Deep Breathe _____

____ O2 _____ Oximetry _____

Initials_____

(place patient label here)

Patient Name: _____

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BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

____ Chest Tube to 20 cm H2O Suction _____

____ Turn every 2 hrs _____

____ Bedrest _____

____ Specialty Bed: _____

____ NPO _____

____ Diet: _____

____ I&O _____

____ Daily weights _____

____ C-Collar _____

____ IV Fluids _____

MEDS:

____ Antibiotic _____

____ PCA _____

____ Other pain meds _____

____ Pepcid 20 mg IV Q 12 hrs. _____

____ Sedative _____

____ Lovenox _____

____ Tetanus _____

____ Wound Care _____

Initials_____

(place patient label here)

Patient Name: _____

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BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

CONSULTS:

____ Intensivist (for) _____

____ Other _____ (for) _____

____ Other _____ (for) _____

____ Other _____ (for) _____

____ Anesthesia (for) _____

____ Pain

____ Nutrition

____ OT

___ PT

____ Rehab

____ SOC Services

Other not above _____

RADIOLOGY:

____ CT

- ____ HEAD _____
- ____ C-SPINE _____
- ____ THORAX _____
- ____ ABD _____
- ____ PELVIS _____
- ____ SPINE _____

____ PLAIN X-RAYS

- ____ C-SPINE _____

Initials_____

(place patient label here)

Patient Name: _____

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BENEFIS HEALTH SYSTEM
Benefis HOSPITALS

PROVIDER ORDERS

____ T-SPINE _____

____ L-SPINE _____

____ PELVIS _____

____ CXR _____

LABORATORY:

____ CBC _____ ____ ABG _____

____ BCS-12 _____ ____ T&C _____

____ BCS-7 _____

____ Other: _____

____ Other: _____

Provider Signature:_____Date:_____Time:_____