

ACUTE STROKE / TIA

Non t-PA ADMIT ORDERS

-CHECK BOX to activate order if applicable

<p>ADMISSION INFORMATION</p> <p>Ht: _____</p> <p>Wt: _____</p>	<p>Admit to: <input type="checkbox"/> HOSPITALIST SERVICE and/or <input type="checkbox"/> Dr. _____</p> <p>Secondary Diagnoses: _____</p> <p>Condition: <input type="checkbox"/> stable <input type="checkbox"/> fair <input type="checkbox"/> guarded <input type="checkbox"/> critical</p> <p>Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other: _____</p> <p>Admit to: Inpatient ICU (see Critical Care Authorization Sheet)</p> <p>Code Status: (see Goldenrod)</p> <p>Advance Directives: <input type="checkbox"/> on chart <input type="checkbox"/> completed at office-please call for copy <input type="checkbox"/> unknown</p>
<p>REFERRALS</p>	<p><input checked="" type="checkbox"/> Notify neurologist of admit – Nursing to call @ 0700 on morning after admit.</p> <p><input checked="" type="checkbox"/> Stroke Rehab Evaluation (CVA pts only) <input type="checkbox"/> Dysphagia <input type="checkbox"/> Discharge Planning <input type="checkbox"/> Financial Services</p> <p><input type="checkbox"/> Wound/Ostomy Care RN <input type="checkbox"/> Social Services <input type="checkbox"/> Other: _____</p> <p>Integrative Health: <input type="checkbox"/> Integrative Medical Consult <input type="checkbox"/> All OK PRN pt request <input type="checkbox"/> Acupuncture</p> <p><input type="checkbox"/> Guided Imagery/Hypnosis <input type="checkbox"/> Massage therapy <input type="checkbox"/> Music Care <input type="checkbox"/> Osteopathy</p>
<p>NURSING CARE</p>	<p>VS and neuro assessment every 15 minutes X 1 hour then every 30 minutes X 1 hour then hourly X 6 hours and then every 2 hours X 24 hours then per unit policy.</p> <p>I&O daily <input type="checkbox"/> weigh daily</p> <p><input type="checkbox"/> Foley catheter—UA dip to Lab with insertion. D/C foley catheter day 3, straight cath if not voided after 8 hours</p> <p><input type="checkbox"/> Cooling blanket for temp above 100° F</p> <p>Activity: <input type="checkbox"/> As tolerated <input type="checkbox"/> Bed rest today, activity as tolerated thereafter</p> <p><input type="checkbox"/> Change position every 2 hours and PRN <input type="checkbox"/> Float heels off mattress</p> <p><input type="checkbox"/> ROM to affected extremities every 4 hours 0700-2200 while awake</p> <p><input type="checkbox"/> Activity progression as tolerated per PT</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Notify physician if: HR <60 or >120 ■ SBP <80 or >160 ■ DBP >100 ■ RR <8 ■ Temp >101.5</p> <p>■ SpO2 <90% ■ Urine Output <20 ml/hr X 2 hours</p> <p>OR</p> <p><input type="checkbox"/> Notify physician if: ■ HR < _____ or > _____ ■ SBP < _____ or > _____ ■ DBP < _____ or > _____</p> <p>■ RR < _____ or > _____ ■ Temp > _____ ■ SpO2 < _____ % ■ Urine Output < _____ ml/hr</p> <p>Patient Education: <input type="checkbox"/> Diabetic teaching <input type="checkbox"/> Smoking cessation education</p>
<p>LAB</p>	<p>On Admit (if not done in ED) <input type="checkbox"/> CBC (auto diff) <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> Lipid panel (fasting) <input type="checkbox"/> ESR</p> <p><input type="checkbox"/> PT/PTT <input type="checkbox"/> If on Warfarin(Coumadin), daily PT/INR <input type="checkbox"/> Other: _____</p> <p>AM Labs: _____</p>
<p>X-RAY</p>	<p><input type="checkbox"/> CXR portable if not done in ER <input type="checkbox"/> To dept for PA and lateral <input checked="" type="checkbox"/> Bilateral carotid ultrasound/doppler</p> <p><input type="checkbox"/> 2D echocardiogram <input type="checkbox"/> Bilateral leg ultrasounds <input type="checkbox"/> MRI brain scan without gadolinium contrast</p> <p><input type="checkbox"/> Non-contrast CT brain scan <input type="checkbox"/> MR angiogram <input type="checkbox"/> Other: _____</p> <p>Reason for exams: _____</p>
<p>Prevention of Aspiration</p>	<p><input type="checkbox"/> NPO (including medications)</p> <p><input checked="" type="checkbox"/> HOB elevated 45°</p> <p><input checked="" type="checkbox"/> Swallow Screening by RN today prior to first drink of water. Call physician for diet order if patient passes this test.</p> <p><input type="checkbox"/> Swallowing evaluation and diet per dysphagia therapist recommendations (pt must be able to maintain alertness for 15 minutes, follow simple commands, and sit at least 60 degrees upright for this evaluation to take place)</p>
<p>DIETARY</p>	<p><input type="checkbox"/> Begin diet today <input type="checkbox"/> Begin diet tomorrow</p> <p><input type="checkbox"/> Nutrition Consult <input type="checkbox"/> Mechanical soft <input type="checkbox"/> Pureed <input type="checkbox"/> Thick liquids <input type="checkbox"/> Regular <input type="checkbox"/> Low Na/Cholesterol</p> <p>Other: _____</p> <p><input type="checkbox"/> Crush all meds and administer with applesauce or pudding if patient has passed swallow evaluation or cleared by speech. Pharmacy review drug regimen for non-crushable meds and contact physician for alternative.</p> <p><input type="checkbox"/> TPN per protocol <input type="checkbox"/> per tube feeding – follow jejunal protocol</p>
<p>RESPIRATORY CARE</p>	<p><input type="checkbox"/> EKG now and every am X _____ days; notify physician of ST-segment elevation or new LBBB <input type="checkbox"/> SpO2 every shift</p> <p><input type="checkbox"/> O2 @ _____ LPM and titrate to maintain SpO2 ≥ 92% or _____ %</p>
<p>PEPTIC ULCER PROPHYLAXIS</p>	<p><input type="checkbox"/> Pantoprazole (Protonix) 40mg PO/IV daily</p>

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VTE Prophylaxis	PATIENT CATEGORY / RISK FACTORS	RISK	PROPHYLAXIS METHOD
	Patient is < 40 years old & no additional risk factor (See High Risk below)	LOW	<input type="checkbox"/> No specific measures; early ambulation
	Patient 40-60 years with limited mobility and no additional risk factor (see High risk below)	MOD	<input type="checkbox"/> Sequential Compression Device OR <input type="checkbox"/> TED hose OR <input type="checkbox"/> Enoxaparin 40mg subQ daily x 10 days OR <input type="checkbox"/> Heparin 5,000 units subQ every 8 hours x 10 days
	Patient >60 yrs or any risk factor such as: CHF, MI, resp. failure, trauma (major or lower extremity), cancer, infection, restricted mobility, ICU admit, obesity, surgery, varicose veins, prior DVT/PE, chronic lung disease, inflammatory bowel disease, smoking, HRT use, pregnancy current or recent.	HIGH	<input type="checkbox"/> Sequential Compression Device OR <input type="checkbox"/> TED hose PLUS <input type="checkbox"/> Enoxaparin 40mg subQ daily x 10 days OR <input type="checkbox"/> Heparin 5,000 units subQ every 8 hours x 10 days
	<p>Contraindications to anticoagulation therapy</p> <ul style="list-style-type: none"> • No mechanical prophylaxis due to: <ul style="list-style-type: none"> <input type="checkbox"/> bilateral amputee <input type="checkbox"/> lower extremity trauma • No anticoagulation at this time due to: <ul style="list-style-type: none"> <input type="checkbox"/> pharmacological VTE prophylaxis: <input type="checkbox"/> platelet count <100,000/mm <input type="checkbox"/> on warfarin prior to admit <input type="checkbox"/> active bleeding (GI bleed) <input type="checkbox"/> cerebral hemorrhage <input type="checkbox"/> CVA <input type="checkbox"/> retroperitoneal bleeding <input type="checkbox"/> bleeding risk <input type="checkbox"/> HIT <input type="checkbox"/> lumbar puncture within 24 hrs <input type="checkbox"/> epidural cath within 24 hours <input type="checkbox"/> hypersensitivity to Heparin or Enoxaparin. <input type="checkbox"/> patient refusal <input type="checkbox"/> other: _____ 	E X C E P T I O N	<input type="checkbox"/> Sequential Compression Device OR <input type="checkbox"/> TED hose
IV	<input type="checkbox"/> Saline Lock <input type="checkbox"/> NS at _____ ml per hour <input type="checkbox"/> add _____ mEq KCL/L <input type="checkbox"/> PICC Consult/Protocol <input type="checkbox"/> Other: _____		
ANTI-COAGULATION	<input checked="" type="checkbox"/> For Ischemic Stroke or TIA – Initiate antiplatelet therapy on admit if not given in the Emergency Department. <input type="checkbox"/> Aspirin 81mg PO daily OR Aspirin 300mg PR daily if patient has not passed swallow evaluation. <input type="checkbox"/> Clopidogrel (Plavix) 75mg PO daily. <input type="checkbox"/> Aspirin 25mg / Dipyridamole 200 mg (Aggrenox) one tab PO BID. <input type="checkbox"/> Warfarin (Coumadin) _____ mg today, then per Pharmacy protocol, target INR _____ <input type="checkbox"/> Enoxaparin (Lovenox) 1mg/kg subQ BID Pharmacy to adjust.		
BLOOD PRESSURE	<p>Ischemic Stroke BP Management: If SBP > 185 or DBP > 110 Target SBP is ≥ 100 and ≤ 180 and DBP is ≥ 60 and ≤ 105</p> <p>Hemorrhagic Stroke BP Management: Target SBP is < 140 and DBP is < 90 mm Hg.</p> <p>For both Ischemic and for Hemorrhagic Stroke use:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Labetalol 10 mg IV; May repeat every 10 minutes X3 doses. <p>If unresponsive to Labetalol or other contraindications to beta blocker effect (asthma or bradycardia) give:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nicardipine (0.2mg/ml) by continuous IV infusion. Start at 5mg/hour. May increase 2.5mg/hour every 5 – 15 minutes, maximum 15 mg/hour. 		
LIPID LOWERING AGENT	<input type="checkbox"/> Simvastatin (Zocor) PO daily: <input type="checkbox"/> 5mg <input type="checkbox"/> 20mg		

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GLYCEMIC CONTROL	<input checked="" type="checkbox"/> If fasting AM blood sugar > 140, notify MD, order a nutrition consult and a Hemoglobin A1C if not already documented this admission. <input type="checkbox"/> Sliding Scale Insulin (See sliding scale order sheet) <input type="checkbox"/> Intensive Insulin Protocol (ICU only – see order sheet)
PAIN	<input type="checkbox"/> Acetaminophen (Tylenol) 650mg PO/PR every 4 hours PRN mild pain ($\leq 3/10$) or temp > 100°F & notify physician if given for temp. Maximum daily dose = 4 grams.
NAUSEA/ VOMITING	<input type="checkbox"/> Prochlorperazine (Compazine) 10mg PO every 6 hrs or 25mg supp every 12 hrs PRN nausea <input type="checkbox"/> Dolasetron (Anzemet) 12.5mg IV every 6 hrs PRN nausea or vomiting <input type="checkbox"/> Metoclopramide (Reglan) 10mg IV every 6 hrs PRN nausea or vomiting <input type="checkbox"/> Ondansetron (Zofran) 4mg IV every 6 hrs PRN nausea or vomiting
BOWEL CARE	<input type="checkbox"/> Follow PDH "Bowel Care Protocol" Docusate Sodium (DSS) 250 mg PO daily Bisacodyl (Dulcolax) Supp PR daily PRN constipation MOM 30 ml PO daily PRN constipation Fleet Enema daily PRN constipation
SLEEP	<input type="checkbox"/> Temazepam (Restoril) 15mg PO every HS PRN insomnia MR X1 in 1 hour <input type="checkbox"/> 7.5 mg(rec. for ≥ 65 years) <input type="checkbox"/> Zolpidem (Ambien) 5mg PO HS PRN insomnia MR X1 in 1 hour as needed
INFECTION PREVENTION	<input type="checkbox"/> Isolation Precautions—for: _____ MRSA LEGAL REQUIREMENTS: <input checked="" type="checkbox"/> MRSA NARES SCREEN ON <u>ADMIT</u> if: Discharged from an acute care hospital within past 30 days; OR Transferred from a nursing facility; OR Admission to ICU (one screen per hospital stay). <input type="checkbox"/> Positive MRSA History—Do not test. Start Glove Precautions. <input checked="" type="checkbox"/> MRSA NARES SCREEN ON <u>DAY OF DISCHARGE</u> if Palm Drive LOS > 10 days AND patient was in ICU. CULTURES: <input type="checkbox"/> wound <input type="checkbox"/> aspiration closed wound <input type="checkbox"/> sputum (PNA) <input type="checkbox"/> U/A with UTI symptoms/Hx <input type="checkbox"/> Blood DIARRHEA: (3 or more unformed stools in past 24 hours)—NOTIFY I.P. x4386 and send stool for C-Difficile Other etiologies: <input type="checkbox"/> Bacterial (stool culture) <input type="checkbox"/> Norovirus <input type="checkbox"/> Parasites x3 (O&P) rate <input type="checkbox"/> Other: _____
VACCINES	Influenza vaccine: per Influenza Vaccination Screening & Administration Protocol Pneumonia vaccine: per Pneumococcal Vaccination Screening & Administration Protocol
OTHER ORDERS	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
PHYSICIAN SIGNATURE: _____ DATE _____ TIME _____	
TRANSCRIBER SIGNATURE: _____ DATE _____ TIME _____	