

# GI BLEED ADMIT ORDERS

## ICU Acute

**CHECK BOX TO ACTIVATE ORDER**

<p><b>ADMISSION INFORMATION</b></p> <p>Ht: _____</p> <p>Wt: _____</p>	<p>Admit to: <input type="checkbox"/> <b>HOSPITALIST SERVICE</b> and/or <input type="checkbox"/> Dr. _____</p> <p><input type="checkbox"/> Med Surg <input type="checkbox"/> Tele (see Telemetry Standing Orders) <input type="checkbox"/> ICU (see Critical Care Authorization Sheet)</p> <p>Diagnosis: GI bleeding <input type="checkbox"/> Upper <input type="checkbox"/> Lower</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>Request prior medical records: <input type="checkbox"/> this hospital <input type="checkbox"/> other hospital: _____</p> <p>Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other: _____</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><b>REFERRALS</b></p>	<p><input type="checkbox"/> Discharge Planning <input type="checkbox"/> Financial Services <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> Speech <input type="checkbox"/> Dysphagia <input type="checkbox"/> Wound/Ostomy Care RN</p> <p><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"/> Music Care <input type="checkbox"/> Guided Imagery/Hypnosis <input type="checkbox"/> Massage therapy <input type="checkbox"/> Osteopathy</p>
<p><b>NURSING CARE</b></p>	<p>VS: <input type="checkbox"/> Per unit Protocol <input type="checkbox"/> Every _____ hours</p> <p>I&amp;O daily <input type="checkbox"/> weigh daily</p> <p><input type="checkbox"/> Foley catheter—UA dip to Lab with insertion</p> <p><input type="checkbox"/> Bed rest <input type="checkbox"/> BSC <input type="checkbox"/> OOB to chair at least _____ daily <input type="checkbox"/> Amb as tol. <input type="checkbox"/> _____</p> <p><input type="checkbox"/> NG tube for active upper GI bleed and lavage until clear ( patient does not have esophageal varices )</p> <p><input type="checkbox"/> Notify physician if: HR &lt;60 or &gt;120 ■ SBP &lt;80 or &gt;160 ■ DBP &gt;100 ■ RR &lt;8 ■ Temp &gt;101.5</p> <p>■ SpO2 &lt;90% ■ Urine Output &lt;20 ml/hr X 2 hours</p> <p>OR</p> <p><input type="checkbox"/> Notify physician if: ■ HR &lt; _____ or &gt; _____ ■ SBP &lt; _____ or &gt; _____ ■ DBP &lt; _____ or &gt; _____</p> <p>■ RR &lt; _____ or &gt; _____ ■ Temp &gt; _____ ■ SpO2 &lt; _____ % ■ Urine Output &lt; _____ ml/hr</p>
<p><b>LAB</b></p>	<p>On Admit (if not done in ED) <input type="checkbox"/> Hemogram <input type="checkbox"/> every 2 hrs <input type="checkbox"/> every 4 hrs <input type="checkbox"/> every 6 hrs <input type="checkbox"/> CBC</p> <p><input type="checkbox"/> CBC Manual Diff <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> PT/INR <input type="checkbox"/> PTT</p> <p><input type="checkbox"/> Cardiac enzymes if age &gt; 45 or hx CAD: <input type="checkbox"/> Myoglobin <input type="checkbox"/> CK-MB <input type="checkbox"/> Troponin-I</p> <p><input type="checkbox"/> AM Labs: <input type="checkbox"/> CBC <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> PT/PTT</p> <p><input type="checkbox"/> H.pylori serology (send out)</p> <p>See "Blood Bank Order " and complete "Informed Consent Transfusion of Blood"</p> <p>AM Labs: _____</p>
<p><b>X-RAY</b></p>	<p>CXR: <input type="checkbox"/> Portable <input type="checkbox"/> Department PA &amp; lateral</p> <p><input type="checkbox"/> KUB for abd distention, pain</p>
<p><b>DIETARY</b></p>	<p><input type="checkbox"/> Nutrition consult <input type="checkbox"/> NPO <input type="checkbox"/> Clear liquids <input type="checkbox"/> Full Liquids <input type="checkbox"/> Regular <input type="checkbox"/> Other: _____</p>
<p><b>RESPIRATORY CARE</b></p>	<p><input type="checkbox"/> SpO2 <input type="checkbox"/> every shift <input type="checkbox"/> every am <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> EKG; notify physician of ST-segment elevation or new LBBB</p> <p><input type="checkbox"/> O2 via _____ @ _____ LPM and titrate to maintain SpO2 ≥ 92% or _____ %</p> <p><input type="checkbox"/> Incentive Spirometer 5-10 repetitions every 1-2 hours WA</p> <p><input type="checkbox"/> Advair _____ mcg/ _____ mcg by DPI, 1 puff BID</p> <p><input type="checkbox"/> Spiriva 1 capsule (18mcg) by DPI daily</p> <p><input type="checkbox"/> Albuterol 2.5mg by HHN every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium (Atrovent) 0.5mg by HHN 4 times daily PRN SOB wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium/Albuterol (Duoneb) by HHN every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Xopenex 1.25mg by HHN _____ hours PRN SOB, wheezing, or desaturation</p> <p>OR</p> <p><input type="checkbox"/> Albuterol 90mcg MDI with spacer 2-4 puffs every _____ hours PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium (Atrovent) MDI 0.5mg with spacer 2-4 puffs 4 times daily PRN SOB, wheezing, or desaturation</p> <p><input type="checkbox"/> Ipratropium/Albuterol (Combivent) MDI 1-2 puffs every _____ hours PRN SOB, wheezing, or desaturation</p>
<p><b>IV ORDERS</b></p>	<p><input type="checkbox"/> Saline lock <input type="checkbox"/> _____ to run @ _____ ml/hour</p> <p><input type="checkbox"/> PICC consult/protocol</p> <p><input type="checkbox"/> See "Blood transfusion Order Sheet"</p>

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<b>INFECTION PREVENTION</b>	<input type="checkbox"/> Isolation Precautions—for: <b>MRSA LEGAL REQUIREMENTS:</b> <input checked="" type="checkbox"/> MRSA NARES SCREEN ON <u>ADMIT</u> if: Discharged from an acute care hospital within past 30 days; <b>OR</b> Transferred from a nursing facility; <b>OR</b> 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 <b>AND</b> patient was in ICU. <b>CULTURES:</b> <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 <b>DIARRHEA:</b> (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:		
<b>GI BLEEDING</b>	<input type="checkbox"/> Use Adult Potassium & Magnesium Replacement Protocol <input type="checkbox"/> Phytonadione (Vitamin K) 10mg IM daily if INR > 2.0 <input type="checkbox"/> Desmopressin (DDAVP) 0.3mcg/kg <input type="checkbox"/> IV <input type="checkbox"/> subq (every 12 hrs x 2) for uremic bleeding <input type="checkbox"/> Octreotide (Sandostatin) 100mcg IV bolus, then 50mcg/hr IV x 72 hrs for advanced liver disease or variceal bleed For advanced cirrhosis or variceal bleed, antibiotic prophylaxis: <input type="checkbox"/> Ceftriaxone (Rocephin) 1g IV every 24 hrs <input type="checkbox"/> Levofloxacin (Levaquin) 500mg IV daily x 5 days <input type="checkbox"/> Pantoprazole (Protonix) 80mg IV load, then 8mg/hr IV continuous drip x 72 hrs <input type="checkbox"/> Propranolol (Inderal) 20mg PO BID after endoscopy (for portal hypertension after endoscopy)		
<b>GLYCEMIC CONTROL</b>	<input type="checkbox"/> Call physician if: fasting blood sugar > 140mm/dl on AM labs <input type="checkbox"/> Sliding Scale Protocol <input type="checkbox"/> Intensive Insulin Protocol (ICU only)		
<b>VTE Prophylaxis</b>	<b>PATIENT CATEGORY / RISK FACTORS</b>	<b>RISK</b>	<b>PROPHYLAXIS METHOD</b>
	Patient is < 40 years old & no additional risk factor (See High Risk below)	<b>LOW</b>	<input type="checkbox"/> No specific measures; early ambulation
	Patient 40-60 years with limited mobility and no additional risk factor (see High risk below)	<b>MOD</b>	<input type="checkbox"/> Sequential compression device <b>OR</b> <input type="checkbox"/> TED hose <b>OR</b> <input type="checkbox"/> Enoxaparin 40mg subQ daily x 10 days <b>OR</b> <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.	<b>HIGH</b>	<input type="checkbox"/> Sequential compression device <b>OR</b> <input type="checkbox"/> TED hose <b>PLUS</b> <input type="checkbox"/> Enoxaparin 40mg subQ daily x 10 days <b>OR</b> <input type="checkbox"/> Heparin 5,000 units subQ every 8 hours x 10 days
	<b>Contraindications</b> to anticoagulation therapy • No mechanical prophylaxis due to: <input type="checkbox"/> bilateral amputee <input type="checkbox"/> lower extremity trauma • No anticoagulation at this time due to: <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:	<b>E X C E P T I O N</b>	<input type="checkbox"/> Sequential compression device <b>OR</b> <input type="checkbox"/> TED hose

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<b>PAIN</b>	<input type="checkbox"/> Morphine Sulfate 4mg IV every 2 hours PRN pain $\geq$ 5/10 or NPO <input type="checkbox"/> Hydrocodone/acetaminophen (Norco) 5/325mg PO every 4 hrs PRN moderate pain $\leq$ 5(10) <input type="checkbox"/> Acetaminophen 650mg PO/PR every 4 hrs PRN mild pain $\leq$ 3(10) or temperature $>$ 100 F $^{\circ}$
<b>NAUSEA/ VOMITING</b>	<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
<b>BOWEL CARE</b>	<input type="checkbox"/> Follow PDH "Bowel Care Protocol" Docusate (DSS)250 mg PO daily                      Bisacodyl (Dulcolax) Supp PR daily PRN constipation MOM 30 ml PO daily PRN constipation              Fleets Enema daily PRN constipation
<b>ANXIETY</b>	<input type="checkbox"/> Lorazepam (Ativan) 1mg PO or IV every 4 hrs PRN anxiety
<b>SLEEP</b>	<input type="checkbox"/> Temazepam (Restoril) 15mg PO every HS PRN insomnia MR X1 in 1 hour <input type="checkbox"/> 7.5 mg (rec. for $\geq$ 65 years) <input type="checkbox"/> Zolpidem (Ambien) 5 mg PO every HS PRN insomnia MR X1 in 1 hour
<b>VACCINES</b>	Influenza vaccine: per Influenza Vaccination Screening & Administration Protocol Pneumonia vaccine: per Pneumococcal Vaccination Screening & Administration Protocol
<b>OTHER ORDERS</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Transcriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_