

Heart Failure Admit Orders

Check box to activate order

<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><input type="checkbox"/> MedSurg <input type="checkbox"/> ICU (see Critical Care Authorization sheet) <input type="checkbox"/> Tele (see Telemetry Standing Orders)</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>Assessment of Left Ventricular Function:</p> <p>Date of assessment: _____ Method: <input type="checkbox"/> echo <input type="checkbox"/> cardiac cath <input type="checkbox"/> nuclear or <input type="checkbox"/> unknown</p> <p>LVEF _____% or <input type="checkbox"/> unknown <input type="checkbox"/> Cardiology consult <input type="checkbox"/> Please call _____ for copy</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 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"/> Financial Services <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>NURSING CARE</p>	<p>VS: <input type="checkbox"/> Per unit Protocol <input type="checkbox"/> Every _____ hours</p> <p>I&O daily weigh daily</p> <p><input type="checkbox"/> Foley catheter—UA dip to Lab with insertion <input type="checkbox"/> Foley catheter PRN inability to void</p> <p><input type="checkbox"/> Fluid restriction _____ ml/day</p> <p><input type="checkbox"/> Reposition patient every 2 hours</p> <p>Activity: <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"/> Other: _____</p> <p>Patient Education: <input checked="" type="checkbox"/> HF Discharge Instructions <input checked="" type="checkbox"/> Discharge Medications</p> <p><input checked="" type="checkbox"/> Smoking Cessation (if patient has smoked within last 12 months)</p> <p><input type="checkbox"/> Notify physician if: HR <60 or >120 <input checked="" type="checkbox"/> SBP <80 or >160 <input checked="" type="checkbox"/> DBP >100 <input checked="" type="checkbox"/> RR <8 <input checked="" type="checkbox"/> Temp >101.5</p> <p><input checked="" type="checkbox"/> SpO2 <90% <input checked="" type="checkbox"/> Urine Output <20 ml/hr X 2 hours <input checked="" type="checkbox"/> CP <input checked="" type="checkbox"/> SOB <input checked="" type="checkbox"/> Rhythm Change</p> <p>OR</p> <p>Notify physician if: <input checked="" type="checkbox"/> HR < _____ or > _____ <input checked="" type="checkbox"/> SBP < _____ or > _____ <input checked="" type="checkbox"/> DBP < _____ or > _____</p> <p><input checked="" type="checkbox"/> RR < _____ or > _____ <input checked="" type="checkbox"/> Temp > _____ <input checked="" type="checkbox"/> SpO2 < _____% <input checked="" type="checkbox"/> Urine Output < _____ ml/hr</p> <p><input checked="" type="checkbox"/> CP <input checked="" type="checkbox"/> SOB <input checked="" type="checkbox"/> Rhythm Change</p>
<p>LAB</p>	<p>On Admit: (if not done in ED) <input type="checkbox"/> CBC <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> Total CK –Iso if elevated <input type="checkbox"/> Troponin I</p> <p><input type="checkbox"/> Myoglobin <input type="checkbox"/> Chest Pain Panel <input type="checkbox"/> PT/INR <input type="checkbox"/> PTT <input type="checkbox"/> D-Dimer <input type="checkbox"/> TSH (send out) <input type="checkbox"/> Mg <input type="checkbox"/> Digoxin</p> <p><input type="checkbox"/> Lipid Panel-fasting <input type="checkbox"/> ABG <input type="checkbox"/> B-type Natriuretic Peptide <input type="checkbox"/> Other _____</p> <p>AM Labs: _____ Daily Labs: _____</p>
<p>X-RAY</p>	<p>CXR: <input type="checkbox"/> PA/Lat <input type="checkbox"/> Portable <input type="checkbox"/> Repeat CXR in am <input type="checkbox"/> Echocardiogram <input type="checkbox"/> Other _____</p>
<p>DIETARY</p>	<p><input type="checkbox"/> Dietary Consult <input type="checkbox"/> NPO <input type="checkbox"/> Clear Liquids <input type="checkbox"/> Full Liquids <input type="checkbox"/> Regular <input type="checkbox"/> _____ Gm Sodium</p> <p><input type="checkbox"/> Cardiac <input type="checkbox"/> _____ Calories ADA <input type="checkbox"/> Other: _____</p>
<p>RESPIRATORY CARE</p>	<p><input type="checkbox"/> EKG; notify physician of ST-segment elevation or new LBBB. SpO2: <input type="checkbox"/> every shift <input type="checkbox"/> with ambulation on room air</p> <p><input type="checkbox"/> O2 via _____ @ _____ LPM and titrate to maintain SpO2 ≥ 92% or _____%</p> <p><input type="checkbox"/> BIPAP: RR _____ I _____ cm E _____ cm @ _____ liter/min and initiate BIPAP protocol (ICU only)</p> <p><input type="checkbox"/> Vent (see Ventilator Orders) (ICU only)</p> <p><input type="checkbox"/> Incentive Spirometer 5-10 repetitions every 1-2 hours WA</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><input type="checkbox"/> Advair _____ mcg/_____ mcg by Dry Powder Inhaler, 1 inhalation BID for SOB, wheezing, or desaturation.</p> <p><input type="checkbox"/> Spiriva 1 capsule (18mcg) by Dry Powder Inhaler daily for SOB, wheezing, or desaturation</p>
<p>IV</p>	<p><input type="checkbox"/> Saline Lock <input type="checkbox"/> _____ to run at _____ ml/hr</p> <p><input type="checkbox"/> PICC consult/protocol</p>
<p>VACCINES</p>	<p>Influenza vaccine: per Influenza Vaccination Screening & Administration Protocol</p> <p>Pneumonia vaccine: per Pneumococcal Vaccination Screening & Administration Protocol</p>
<p>GLYCEMIC CONTROL</p>	<p><input type="checkbox"/> Notify physician if AM fasting blood sugar is > 140</p> <p><input type="checkbox"/> Sliding Scale Insulin (See sliding scale order sheet)</p> <p><input type="checkbox"/> Intensive Insulin Protocol (ICU only – see order sheet)</p>

Heart Failure Admit Orders

DIURETICS	<input type="checkbox"/> Furosemide (Lasix) ____ mg PO/IV (circle one) every ____ <input type="checkbox"/> HCTZ ____ mg PO every ____ <input type="checkbox"/> Bumetanide (Bumex) ____ mg PO/IV (circle one) every ____ <input type="checkbox"/> Metolazone (Zaroxolyn) ____ mg PO every ____ <input type="checkbox"/> ICU patients – Bumetanide drip at ____ mg/hour		
CARDIAC MEDICATIONS	ACE Inhibitor: (circle one) (Benazepril / Captopril / Enalapril / Lisinopril / Ramipril) ____ mg every ____ hrs. <input type="checkbox"/> Hold for SBP < ____ <input type="checkbox"/> Contraindicated: <input type="checkbox"/> hypotension <input type="checkbox"/> renal insufficiency <input type="checkbox"/> hyperkalemia <input type="checkbox"/> angioedema <input type="checkbox"/> Hx drug intolerance Beta Blocker: ____ (Carvedilol / Atenolol / Metoprolol) <input type="checkbox"/> Hold for SBP < ____ HR < ____ <input type="checkbox"/> Contraindicated: <input type="checkbox"/> bronchospasm <input type="checkbox"/> bradyarrhythmia <input type="checkbox"/> hypotension <input type="checkbox"/> Other: ____ <input type="checkbox"/> Acute AMI within first 24 hrs of admit with history of HF ARB: ____ (LOSARTAN / VALSARTAN) <input type="checkbox"/> Hold for SBP < ____ <input type="checkbox"/> Contraindicated: <input type="checkbox"/> hypotension <input type="checkbox"/> renal insufficiency <input type="checkbox"/> hyperkalemia <input type="checkbox"/> angioedema <input type="checkbox"/> Other: ____		
VASODILATOR	<input type="checkbox"/> NTG oint.2% ____ inch(es) every ____ hrs (remove for SBP < 90) <input type="checkbox"/> Isosorbide dinitrate (Isordil) ____ mg every ____ (hold for SBP < ____) <input type="checkbox"/> Isosorbide mononitrate (Imdur) ____ mg every ____ (hold for SBP < ____) <input type="checkbox"/> ICU patients – NTG IV drip: start at ____ mcg/kg/min titrate to relieve chest pain. Keep SBP > ____ <input type="checkbox"/> ICU patients – NTG IV drip: start at ____ mcg/min titrate to relieve chest pain. Keep SBP > ____		
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
	Contraindications to anticoagulation therapy <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
ANTIPLATELET/ ANTICOAGULANT THERAPEUTIC REGIME	<input type="checkbox"/> Aspirin (enteric coated) ____ PO daily <input type="checkbox"/> Contraindicated: <input type="checkbox"/> allergy <input type="checkbox"/> GI bleeding <input type="checkbox"/> Clopidogrel (Plavix) ____ loading dose today, then 75mg PO daily <input type="checkbox"/> Enoxaparin (Lovenox) 1mg/kg subQ every 12 hrs; Pharmacy to adjust. <input type="checkbox"/> Warfarin per protocol (see Coumadin Order Sheet)		
PEPTIC ULCER PROPHYLAXIS	<input type="checkbox"/> Famotidine (Pepcid) 20 mg PO/IV BID <input type="checkbox"/> Pantoprazole (Protonix) 40mg PO/IV daily		

Heart Failure Admit Orders

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: _____
PAIN	<input type="checkbox"/> Acetaminophen (Tylenol) 650mg PO/PR every 4 hours PRN mild pain ($\leq 3/10$), temp > 101°F <input type="checkbox"/> Hydrocodone/Acetaminophen (Norco) 5/325mg 1 tab PO every 4 hours PRN mild to moderate pain (< 5/10) <input type="checkbox"/> Hydrocodone/Acetaminophen (Norco) 5/325mg 2 tabs PO every 4 hours PRN moderate to severe pain ($\geq 5/10$) <input type="checkbox"/> Morphine Sulfate _____mg IV every 2 hours PRN pain $\geq 5/10$ or NPO
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 Supp PR daily PRN constipation MOM 30 ml PO daily PRN constipation Fleet Enema daily PRN constipation
ANXIETY	<input type="checkbox"/> Lorazepam (Ativan) _____mg IV / PO (circle one) every _____hrs PRN anxiety OR <input type="checkbox"/> Alprazolam (Xanax) 0.25 mg PO every 6 hours PRN anxiety
SLEEP	<input type="checkbox"/> Temazepam (Restoril) PO HS PRN sleep MR X 1 in 1 hour <input type="checkbox"/> 7.5 mg (rec. for >65 yrs) <input type="checkbox"/> 15 mg (rec. for <65 yrs) OR <input type="checkbox"/> Zolpidem (Ambien) 5 mg PO HS PRN sleep MR X 1
OTHER MEDICATIONS	<input type="checkbox"/> Digoxin _____ mg PO/IV (circle one) every _____ <input type="checkbox"/> KCL _____meq PO / IV (circle one) every _____ <input type="checkbox"/> ICU patients: per KCl/Mag Replacement Protocol <input type="checkbox"/> Zocor _____ <input type="checkbox"/> Spironolactone 25 mg PO daily <input type="checkbox"/> Nicotine Patch: <input type="checkbox"/> 7 mg daily <input type="checkbox"/> 14 mg daily <input type="checkbox"/> 21 mg daily <input type="checkbox"/> Mylanta 30 ml PO every 4 hrs PRN indigestion <input type="checkbox"/> Acetaminophen 650 mg PO every 4 hrs PRN temp > 101 or mild pain (max daily dose = 4 gms)
OTHER ORDERS	<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: _____