

Palm Drive Hospital

HYPERTENSIVE EMERGENCY ADMIT ORDERS

CHECK BOX to activate order if applicable

ADMISSION INFORMATION	Admit to: <input type="checkbox"/> HOSPITALIST SERVICE and/or <input type="checkbox"/> Dr. _____ <input type="checkbox"/> ICU (see Critical Care Authorization sheet) Admission diagnoses: _____ Ht: _____ Medication allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other: _____ Wt: _____ Condition: <input type="checkbox"/> stable <input type="checkbox"/> fair <input type="checkbox"/> guarded <input type="checkbox"/> critical Code Status (see Goldenrod) Advance Directives: <input type="checkbox"/> on chart <input type="checkbox"/> completed at office-please call for copy <input type="checkbox"/> unknown
REFERRALS	<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 <input type="checkbox"/> Social Services <input type="checkbox"/> Other: _____ Integrative Health: <input type="checkbox"/> Integrative Medical Consult <input type="checkbox"/> All OK PRN pt request <input type="checkbox"/> Acupuncture <input type="checkbox"/> Guided Imagery/Hypnosis <input type="checkbox"/> Massage therapy <input type="checkbox"/> Music Care <input type="checkbox"/> Osteopathy
NURSING CARE	VS: <input type="checkbox"/> Per Unit protocol <input type="checkbox"/> Every _____ hour(s) I&O daily <input type="checkbox"/> weigh daily <input type="checkbox"/> Foley catheter—UA dip to Lab with insertion Activity: <input type="checkbox"/> Bed rest <input type="checkbox"/> BRP <input type="checkbox"/> OOB to chair every _____ <input type="checkbox"/> Ambulate as tol. <input type="checkbox"/> Notify physician if: HR <60 or >120 ■ SBP <80 or >160 ■ DBP >100 ■ RR <8 ■ Temp >101.5 ■ SpO2 <90% ■ Urine Output <20 ml/hr X 2 hours OR <input type="checkbox"/> Notify physician if: ■ HR < _____ or > _____ ■ SBP < _____ or > _____ ■ DBP < _____ or > _____ ■ RR < _____ or > _____ ■ Temp > _____ ■ SpO2 < _____ % ■ Urine Output < _____ ml/hr
LAB	On Admit if not done in ED: <input type="checkbox"/> CBC <input type="checkbox"/> Manual Differential <input type="checkbox"/> BMP <input type="checkbox"/> CMP <input type="checkbox"/> U/A <input type="checkbox"/> Other: _____ AM Labs: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> PT <input type="checkbox"/> PTT <input type="checkbox"/> Other: _____
X-RAY	<input type="checkbox"/> CXR PA & Lat <input type="checkbox"/> CXR Portable <input type="checkbox"/> Cardiac echocardiogram <input type="checkbox"/> Carotid Doppler/Ultrasounds
DIETARY	<input type="checkbox"/> Dietary Consult <input type="checkbox"/> No Added Salt <input type="checkbox"/> Cardiac diet <input type="checkbox"/> Other: _____
RESPIRATORY CARE	<input type="checkbox"/> SpO2 <input type="checkbox"/> every shift <input type="checkbox"/> every am <input type="checkbox"/> Other: _____ <input type="checkbox"/> EKG; notify physician of ST-segment elevation or new LBBB <input type="checkbox"/> O2 via _____ @ _____ LPM and titrate to maintain SpO2 ≥ 92% or _____ % <input type="checkbox"/> Incentive Spirometer 5-10 repetitions every 1-2 hours WA <input type="checkbox"/> Advair _____ mcg/ _____ mcg by DPI, 1 puff BID <input type="checkbox"/> Spiriva 1 capsule (18mcg) by DPI daily <input type="checkbox"/> Albuterol 2.5mg by HHN every _____ hours PRN SOB, wheezing, or desaturation <input type="checkbox"/> Ipratropium (Atrovent) 0.5mg by HHN 4 times daily PRN SOB wheezing, or desaturation <input type="checkbox"/> Ipratropium/Albuterol (Duoneb) by HHN every _____ hours PRN SOB, wheezing, or desaturation <input type="checkbox"/> Xopenex 1.25mg by HHN every _____ hours PRN SOB, wheezing, or desaturation OR <input type="checkbox"/> Albuterol 90mcg MDI with spacer 2-4 puffs every _____ hours PRN SOB, wheezing, or desaturation <input type="checkbox"/> Ipratropium (Atrovent) MDI 0.5mg with spacer 2-4 puffs 4 times daily PRN SOB, wheezing, or desaturation <input type="checkbox"/> Ipratropium/Albuterol (Combivent) MDI 1-2 puffs every _____ hours PRN SOB, wheezing, or desaturation
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: _____
IV ORDERS	<input type="checkbox"/> Saline Lock <input type="checkbox"/> _____ to run at _____ ml/hour <input type="checkbox"/> PICC consult/protocol
GLYCEMIC CONTROL	<input type="checkbox"/> Notify physician if AM fasting blood sugar is > 140 <input type="checkbox"/> Sliding Scale Insulin (See sliding scale order sheet) <input type="checkbox"/> Intensive Insulin Protocol (ICU only – see order sheet)

HYPERTENSIVE EMERGENCY

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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
	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
BLOOD PRESSURE	<input type="checkbox"/> Labetalol (Trandate) 10mg IV every 15 minutes to achieve Systolic BP below 160 and Diastolic BP below 90 OR a mean BP below 110. If ineffective after ___ doses, increase dose to: <ul style="list-style-type: none"> <input type="checkbox"/> 20mg IV every 15 minutes, to a max of ___ mg or <input type="checkbox"/> 30mg IV every 15 minutes, to a max ___ mg or <input type="checkbox"/> 40mg IV every 15 minutes, to a max of ___ mg or <input type="checkbox"/> Start Labetalol drip at 2mg/min (alternative approach) <input type="checkbox"/> Nitroglycerine infusion to achieve Systolic BP below 160 and Diastolic BP below 90 OR a mean BP < 110 <input type="checkbox"/> Nitroprusside infusion to achieve Systolic BP below 160 and Diastolic BP below 90 OR a mean BP < 110 <input type="checkbox"/> Hydralazine 10mg IV every 2 hours to achieve Systolic BP below 160 and Diastolic BP below 90 OR a mean BP < 110 		
AGITATION	<input type="checkbox"/> Haloperidol (Haldol) 1mg IV every 4 hours PRN agitation <input type="checkbox"/> Haloperidol 2mg IV every 4 hours PRN agitation <input type="checkbox"/> Other: _____		
PEPTIC ULCER PROPHYLAXIS	<input type="checkbox"/> Famotidine (Pepcid) 20 mg PO/IV BID <input type="checkbox"/> Pantoprazole (Protonix) 40mg PO/IV daily		
PAIN	<input type="checkbox"/> Tylenol 650mg PO/PR every 4 hours PRN mild pain (3/10 or less), temp greater than 38.5 <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 (≥ 5/10) <input type="checkbox"/> MORPHINE Sulfate 4mg IV every 2 hours PRN pain ≥ 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 (DSS) 250 mg PO daily Bisacodyl (Dulcolax) Supp PR daily PRN constipation		

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	MOM 30 ml PO daily PRN constipation	Fleets Enema daily PRN constipation
ANXIETY	<input type="checkbox"/> Lorazepam (Ativan) 1mg PO or IV every 4 hours PRN anxiety <input type="checkbox"/> Lorazepam 2mg PO or IV every 4 hours PRN anxiety <input type="checkbox"/> Other:	
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) 5 mg PO PRN HS MR X1	
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"/> <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 _____