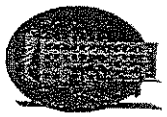
HUC - Assignment #2



Opportunity Medical Center
1912 Lake Pleasant Dr.
Pleasantville, Anystate 19480

☐ STAT

PLEASE USE BALLPOINT PEN

POST OPERATIVE VASCULAR SURGERY ORDERS

1. Admit to: ☐ CVICU ☑ Telemetry ☐ Interventional Unit
2. Procedure: Angioplasty & stents Time of Last Dose of Antibiotic in OR: 1000
3. Admitting Physician: George Felton Consult: James Blair
4. Nursing Care:
   - ✓ Vital signs every 5 minutes X 3, then every 15 minutes X 4 until stable, then per unit routine.
     - For Bypass Procedures: Pulse checks every 1 hour for 24 hours then every 4 hours.
     - For CEA patients: Neuro checks every 15 minutes X 8, every 1 hour X 4, every 2 hours X 18 hours then every 4 hours
     - For CEA patients: Head of bed ≥ 30 degrees
     - Strip JP drains every 1 hour, may discontinue when < 30 mL of drainage per shift
   - ✓ Foley to gravity, notify physician for urine output < 30 mL per hour
     - Daily weight, I&Os
     - Bair Hugger for temp < 96.5°F.
5. Respiratory Care:
   - ✓ Oxygen 2-4 liters per nasal cannula - titrate to keep O_2 sats ≥ 92%
     - Incentive spirometry every 1 hour while awake
6. Incision Care: for bleeding & I x 4 then q4
   - ☐ Cleanse with 50/50 Saline/Hydrogen Peroxide, apply Bacitracin, cover with Island dressing. Change daily.
7. Activity: _____
8. ☐ PT Consult
9. ☐ OT Consult
10. Smoking Cessation Education PRN (if patient has smoked within the past 12 months).
11. Diet:
    - ✓ NPO until awake and alert, then advance to cardiac diet (If diabetic 1800 Kcal ADA).
    - ☐ Other: _____
12. Labs:
    - ✓ CBC, BMP in AM
    - ☒ PT, PTT in AM
      - PT/INR daily if on Warfarin
      - Other: _____
13. IV Fluids:
    - ☐ Lactated Ringers at 120 mL/hr. Saline lock in AM if tolerating PO fluids.
    - ☐ $D_5W/0.45\%$ NaCL at _____ mL/hr. Saline lock in AM if tolerating PO fluids.
    - ☐ $D_5W/0.9\%$ NaCL at _____ mL/hr. Saline lock in AM if tolerating PO fluids.
    - ☐ D_5W 850 mL with 150 mEq (150 mL) Sodium Bicarbonate (Total Volume 1000 mL) at 1mL/kg/hr x 6 hours.
    - ☐ Other: _____ at _____ mL/hr. Saline lock in AM if tolerating PO fluids.
14. Emergency Protocol
15. Follow Potassium and Magnesium Protocol
16. IV Medications:
    - ☒ Cefazolin (Ancef®) 1 gm IV every 8 hours X 2 doses or _____
    - ☐ Dextran 40 IV at 20 mL/hour. Discontinue at 0600 the following morning.
    - ☒ Nitroglycerin 5-150 mcg/min IV infusion. Titrate to keep SBP < 150 mmHg ~~or _____ mmHg~~ 4/7
    - ☐ Nitroprusside (Nipride®) with Sodium Thiosulfate - Give 0.5 to 3 mcg/kg/min IV infusion to keep SBP < 150 mmHg or ____ mmHg
    - ☐ Nicardipine (Cardene®) 1-10 mg/hour IV infusion. Titrate to keep SBP < 150 mmHg or _____ mmHg

ANOTHER BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED ☐

Patient Label

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☐ STAT

PLEASE USE BALLPOINT PEN

POST OPERATIVE VASCULAR SURGERY ORDERS

17. Medications:

ANTIPLATELET:

- ☒ Aspirin 81 mg PO daily
- ☐ ECASA 325 mg PO daily
- ☐ Clopidogrel (Plavix®) 300 mg PO ~~or _____ mg PO now (Loading Dose)~~
- ☒ Clopidogrel (Plavix®) 75 mg PO daily, start POD #1

BETA BLOCKER:

- ☐ Metoprolol 25 mg or _____ mg PO BID, Hold for HR < 55 BPM, SBP < 90 mmHg, Radiographic/Clinical Evidence of Active CHF
- ☐ Or: _____, Hold for HR < _____BPM or SBP < _____mmHg
- ☐ **DO NOT GIVE A BETA BLOCKER. Reason:** _____

ACEI/ARB:

- ☐ Captopril 6.25 mg PO every 8 hours, Hold for SBP < 100 mmHg
- ☐ Losartan 25mg PO daily, Hold for SBP < 100 mmHg
- ☐ Or: _____, or SBP < _____ mmHg
- ☐ **DO NOT GIVE AN ACEI/ARB. Reason:** _____

STATIN:

- ☒ Pravastatin 80 mg PO at bedtime or _____
- ☐ **DO NOT GIVE A STATIN. Reason:** _____

OTHER MEDICATIONS:

- ☐ Enoxaparin (Lovenox®) 40 mg subcutaneous daily for DVT prophylaxis
- ☐ Famotidine (Pepcid®) 20 mg IV/PO BID
- ☐ Labetalol 5-10 mg IV every 2 hours PRN SBP > 150 mmHg or _____ mmHg
- ☐ Finger Stick Blood Glucose AC and HS. Initiate moderate sliding scale insulin protocol unless otherwise indicated below
  Sliding Scale Insulin Per Protocol: ☐ Mild ☐ Moderate ☐ High ☐ Aggressive
- (○) Lorazepam 1 mg PO/IV every 4 hours PRN anxiety
- Morphine 2-6 mg IV every 4 hours PRN pain
- ☐ Hydromorphone (Dilaudid®) 0.2-0.5 mg IV every 2 hours PRN pain. Discontinue order for Morphine.
- Oxycodone 5 mg/Acetaminophen 325 mg (Percocet®) 1-2 tablets PO every 4 hours PRN pain (Do NOT exceed 4 grams of acetaminophen in 24 hours)
- (○) Acetaminophen 650 mg PO/PR every 4 hours PRN discomfort / headache (Do NOT exceed 4 grams of acetaminophen in 24 hours)
- Ondansetron (Zofran®) 4 mg IV every 6 hours PRN nausea/ vomiting
- Zolpidem (Ambien®) 5 mg PO at bedtime PRN sleep. May repeat X 1.
- BCOC Protocol
- Antacid of Choice
- ☐ SVN: Albuterol 2.5 mg/3 mL every 4 hours PRN wheezing

18. Additional medications / Other Orders: Avapro 300/12.5 mg PO q AM
Coreg 25 mg q AM Zetia 10 mg PO q HS

19. Transfer patient to telemetry in AM if patient is hemodynamically stable and neurologically intact, there is no evidence of bleeding, no vasodilator/vasopressor infusions, and AM labs are WNL.

Physician Signature: Henry Fenton MD Date: X/XX/XX Time: 15 am/(pm)

ANOTHER BRAND OF DRUG IDENTICAL IN FORM AND CONTENT MAY BE DISPENSED UNLESS CHECKED ☐

Patient Label

Diagnosis

Admit Date to Family Medicine _____
Admit Date to Hospital _____

Allergies

Age:

Advance Care Plan

Review Date
_____

Past Hx

Language Spoken:

Health Directive
❒ Yes ❒ No

Physician Consults

Risk Management:
Close Observation: ❒ q15 min ❒ q30 min
Side Rails ❒ 2 ❒ 3 ❒ 4
High Risk For: ❒ Falls ❒ Wandering
❒ Aggression
❒ Bed Check ❒ Chair Check
❒ Braden Scale # _____ Reassess_____
❒ Falls Risk Assess. #_____ Reassess _____
Oriented: ❒ Person ❒ Place ❒ Time

Contact:
Name: Relationship Phone
_____ H)_____
W)_____
_____ H)_____
W)_____

Activity **Transfer Logo Updated** ❒ **Date** _____
❒ Self ❒ Assist: SBA ❒1 ❒2
❒ Hoyer ❒ Sara ❒ Mediman
❒ Bedrest ❒ BRP Only
❒ Turns ❒ Chair _____
❒ Ambulate ❒ Walker ❒ Cane
❒ Physio _____
ROM q _____
❒ HOB Elevate ❒ FOB Elevate

Hygiene
Bath: ❒ Self ❒ Assist ❒ Complete
Tub Day _____ ❒ Shower
❒ Dentures _____
❒ Hearing Aids _____ ❒ Glasses

Elimination:
❒ BR ❒ Bedpan ❒ Urinal
❒ Commode ❒ Foley ❒ Incontinent
❒ Brief ❒ Incl Pad
❒ Ostomy Change Bag _____
BM Due _____
BR Routine _____
❒ Bowel Sounds _____

Vital Signs
Frequency _____ _____
❒ Crani Checks _____
❒ Reassess _____

Nutrition
❒ Weight _____
Diet _____
❒ NPO ❒ Self ❒ Assist ❒ Feed
❒ I/O ❒ Push Fluids
❒ Fluid Restrictions _____
❒ Crush Meds _____
❒ Tube Feed: _____
❒ Aspir. & Flush: _____
❒ NG Tube ❒ Low Suction
❒ Clamped _____
Change Bag _____

Intravenous Therapy
Site _____ Change _____
Sol'n/ Rate _____
Site _____Change _____
Sol'n/Rate _____
TPN: Amino: _____
Lipids _____
❒ Heparin Protocol
PTT Due _____

❒ PICC Line ❒ Central Line
Line Drsg D/T → _____

Oxygenation
❒ O2 _____ ❒ O2 Sats_____
❒ Chest Sounds _____
❒ Chest Physio
❒ Suction ❒ DB &C
Other _____

Nursing Dx: Focus Update:	Nursing Interventions	Teaching/Goals/Additional Comments
		Service Consult ❒ OT _____ ❒ PT _____ ❒ SW _____ ❒ Speech _____ ❒ Dietary _____ ❒ Other _____
Dressings: **Drsg #1 Site** _____ **Type** _____ **Change** _____ **Drsg #2 Site** _____ **Type** _____ **Change** _____ **Drsg #3 Site** _____ **Type** _____ **Change** _____ Sutures/Staples In _____ Out _____ Orthotics _____ Teds: On @ _____ Off @ _____ CWC _____	**Blood Work** **Date Type Repeat** **In House Tests:** **Date Type Dept.** **Referred Out Procedures:** Test _____ Date/Time _____ Facility _____ Trans. Time _____ Type of Trans _____ Escort: ❒ RN ❒ HCA ❒ Confirmed Test _____ Date/Time _____ Facility _____ Trans. Time _____ Type of Trans _____ Escort: ❒ RN ❒ HCA ❒ Confirmed	**Pass** ❒ Yes ❒ No ❒ PRN Date Ordered _____ **Discharge Planning** ❒ Home ❒ Home with Services ❒ Home Care Consult Date **Panelling** ❒ Papers Completed _____ Panel Date _____ **Med Card** ❒ Yes ❒ No Date Ordered _____ RX on Chart: ❒ Yes ❒ No Own Meds: ❒ Yes ❒ No Valuables: ❒ Yes ❒ No Date Assessed: _____ **Pacemaker:** ❒ Yes ❒ No **Defibulator:** ❒ Yes ❒ No (If Yes mark in Red)

ROBERTSON GENERAL HOSPITAL

SCHEDULED MEDICATIONS

ALLERGIES: ____________________

ORDER DATE	REORDER DATE	START DATE	STOP DATE	SCHEDULE	MEDICATION/DOSE/ROUTE	YEAR DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.
			RN								

ROBERTSON GENERAL HOSPITAL

NON-SCHEDULED MEDICATIONS

ALLERGIES: ____________________

NONRECURRING MEDICATION	RN	DATE TIME	START DATE RN	STOP DATE RN	PRN MEDICATIONS	YEAR DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.

ROBERTSON GENERAL HOSPITAL

SCHEDULED MEDICATIONS

ALLERGIES: ______________________________

ORDER DATE	REORDER DATE	START DATE	STOP DATE	SCHEDULE	MEDICATION/DOSE/ROUTE	YEAR DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.
			RN								

ROBERTSON GENERAL HOSPITAL

NON-SCHEDULED MEDICATIONS

ALLERGIES: ______________________

NONRECURRING MEDICATION	RN	DATE TIME	START DATE RN	STOP DATE RN	PRN MEDICATIONS	YEAR DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.	DATE TIME INIT.

*** PLEASE COMPLETE THE INFORMATION BELOW, PRINT CLEARLY ***

NAME OF PHYSICIAN ORDERING TEST: ..... (LAST) ..... (FIRST)

REFERRING INSTITUTION NAME AND ADDRESS OR CODE:

IF AN ADDITIONAL REPORT IS REQUIRED, PLEASE COMPLETE THE FOLLOWING:

PHYSICIAN NAME: .....

ADDRESS: .....

CITY: ..... PROV. ..... POSTAL CODE .....

TELEPHONE NO. ..... FAX NO. .....

ENCOUNTER NO.: ..... LOCATION (WARD/CLINIC): .....

PATIENT NAME: ..... (LAST) ..... (FIRST)

DATE OF BIRTH: ..... (DD/MM/YYYY) SEX: ☐ F ☐ M

FACILITY PATIENT ID NO.: .....

PHIN (9 DIGITS): .....

PHYSICIAN/PHYSICIAN NO.: .....

COLLECTION DATE: .....

COLLECTION TIME: .....

COLLECTED BY: .....

SPECIMEN ID # HSC LAB USE ONLY

SCHEDULED COLLECTION: DATE: _____ TIME: ☐ 0800 ☐ OTHER: _____

COLLECTED BY: ☐ VENIPUNCTURE ☐ INDWELLING LINE ☐ ABOVE SHUT-OFF IV

	CHEMISTRY			CHEMISTRY			CHEMISTRY			ENDOCRINE TESTS	
☐	Sodium	NA	☐	Alkaline Phosphatase	ALK	☐	Ammonia Send on ice	AMM	☐	ACTH Send on ice	ACTH
☐	Potassium	K	☐	ALT (SGPT)	ALT	☐	Angiotensin Conv. Enz.	ACE	☐	Cortisol	COR
☐	Chloride	CL	☐	AST (SGOT)	AST	☐	Beta-Hydroxybutyrate	BHB	☐	DHAS	DHAS
☐	Total CO_2 (Bicarbonate)	CO2	☐	Bilirubin, Total	TB	☐	Ceruloplasmin	CERU	☐	Estradiol	E2
☐	Glucose	G	☐	Bilirubin, Direct	DB	☐	Ethanol	ETO	☐	FSH	FSH
☐	Urea	U	☐	γ-Glutamyl Transferase	GGT	☐	FEP	FEP	☐	Growth Hormone	GH
☐	Creatinine	CR	☐	LD	LD	☐	Ferritin	FER	☐	HCG (Quantitative)	HCGQ
☐	Calcium	CA	☐	Lipase	LIP	☐	Glycated Hemoglobin	GYHB	☐	17-Hydroxyprogesterone	PR17
☐	Phosphate	P	☐	Uric Acid	UA	☐	Haptoglobin	HPT	☐	Insulin	INS
☐	Magnesium	MG	☐	Iron	IRON	☐	Homocysteine Send on ice	HCQ	☐	LH	LH
☐	CK	CK	☐	TIBC	TIBC	☐	IgE	IGE	☐	Progesterone	PGN
☐	Troponin T	TNT	☐	Osmolality	OS	☐	Ionized Calcium	ICA	☐	Prolactin	PL
☐	Myoglobin	SMYO	☐	Alpha-Fetoprotein	AFP	☐	Lactic Acid Send on ice	LAC	☐	SHBG	SHBG
☐	Total Protein	TP	☐	Beta-2 Microglobulin	BZM	☐	Lead	PB	☐	Testosterone	TST
☐	Albumin	AL	☐	CA125	CA1	☐	Prealbumin	PALB	☐	FAI	FAI
☐	Lipoprotein Profile (Includes CH, TG, HDL, LDL)	LIPP	☐	CA 15-3	CA15	☐	PTH Send on ice	PTH	☐	T3, Free	FT3
			☐	CA 19-9	CA19	☐	Vitamin B12	B12	☐	T4, Free	FT4
☐	Cholesterol	CH	☐	Carcinoembryonic Antigen	CEA	☐	Vitamin D25	D25	☐	TSH	TSH
☐	Triglyceride	TG	☐	PSA	PRSA	☐	Zinc	ZN	☐	Thyroperoxidase Antibodies	TPO

	HEMATOPATHOLOGY	
☐	Complete Blood Count (includes 5 cell differential)	CBC
☐	Blood Film Review (**Reason must be given**) Reason:	SLR
☐	Reticulocyte Count	RETA
☐	Sedimentation Rate (ESR)	ESR
☐	Sickle Cell Screen	HSS
☐	Malaria	MAL
☐	Cold Agglutinin Screen	HCA
☐	Glucose-6-Phosphate Dehydrogenase	GPD
☐	PT/INR/Pflb	PT
☐	APTT	APTT
☐	Fibrinogen	CFIB
☐	D-Dimer (Qualitative)	DDIM
☐	Lupus Inhibitor	LUPS
☐	Factor V Leiden	MOL
☐	Prothrombin Variation (G20210A)	MOL
☐	Heinz Body Screen	HBA

	DRUG LEVELS				
☐	Acetaminophen	ACTM	☐	Mycophenolic Acid	MPA
☐	Amiodarone	AMIO	☐	Phenobarbital	PHEN
☐	Carbamazepine	CARB	☐	Phenytoin	PYN
☐	Cyclosporin	CY	☐	Salicylate	SAL
☐	Digoxin	DIG	☐	Sirolimus	SIRO
☐	FK506	FK5	☐	Theophylline	TEO
☐	Gentamicin	GENT	☐	Tobramycin	TOBR
☐	Lithium	LI	☐	Valproic Acid	VALP
☐	Methotrexate	MTX	☐	Vancomycin	VANC

LAST DOSE: TIME: DATE: (D/M/Y)

NEXT DOSE: TIME: DATE: (D/M/Y)

IV FINISH: TIME:

SPECIMEN COLLECTION INSTRUCTIONS

Tests marked in red require special collection and/or transport.
Consult the Lab Information Manual or call the laboratory.

OTHER TESTS (Please Print)

CLINICAL INFORMATION

URGENT

CHEMISTRY/HEMATOPATHOLOGY TEST REQUISITION

LABORATORY TEST REQUEST BLOOD, SERUM OR PLASMA