NORTH CAROLINA BAPTIST HOSPITAL
PHYSICIAN ORDER FORM

PHYSICIANS: All orders should be written generically and using the Metric **System; include the physician's signature, PRINTED name, ID** Number, beeper number and the date/time. A generically and therapeutically alternative drug as approved by the P & T Committee may be dispensed unless the order is specifically designated "Dispense as Written"."

Form Approved by Medical Record Informatics Technology Committee: _10/05_____

FAX **TITLE: Moderate Ischemic Stroke Admission Orders** **Page 1 of 4**

DATE	
TIME	**(PLEASE CIRCLE OR CHECK APPROPRIATE ORDERS AND FILL IN BLANKS AS NEEDED)**

DIAGNOSIS: **ALLERGIES:**

1. ☐ Admit to Neurology Floor Bed ☐ Admit to Neurology Floor Telemetry Bed
   ☐ Admit to Neurology Floor Acute Care Bed ☐ Admit to Intermediate Care Bed
2. Attending:_____ HO:_____
   Beeper:_____
3. Condition: ☐ Good ☐ Fair ☐ Serious ☐ Critical
4. Cardiac Monitor if history of or suspected arrhythmia or cardiac ischemia (**Complete orders for Centralized Telemetry Surveillance Unit)**
   ☐ D/C monitor after 24 hours if no dysrhythmia intervention required.
5. Vital Signs , Oxygen Saturation and Neuro Checks : □ every 4 hrs.X24 hours , then every 8 hrs.
   ☐ **On day 3** change vital signs, oxygen saturation and neuro checks to every shift
   ☐ D/C O2 sats if >92% on room air
   Call HO if: T>101.5° F, SBP <90mmHg or >210mmHg., DBP>110 mmHG, HR< 50 bpm OR >120 bpm, RR<12/min or >24/min., O2 Sat <93% or_____, or Urine output <240cc/8 hrs.
6. Intake/ Output: ☐ Routine: Total every 8 hrs (every 2hr in ACB & IMC)
   Strict: Quantify urine output . Total every 4 hrs. (every 2 hr. in ACB& IMC)
7. Activity: ☐ Turn every 2 hrs. if immobile, or while in bed (Right- Back – Left, Right-Back- Left)
   ☐ Passive ROM bid to affected extremities
   ☐ OOB to chair daily; OOB to chair bid **beginning day 2**
   ☐ Other_____
8. Weight: ☐ On admission
9. ☐ Hemetest stools if on Heparin or Warfarin (Coumadin®)
10. Glucometer checks if diabetic: ☐ bid before breakfast and supper ☐ AC and at bedtime
    ☐ Sliding Scale Insulin per Standard Dose Protocol
11. Residual Checks every 4 hours if on enteral feedings
12. ☐ Bladder management Protocol
13. ☐ Bowel Management protocol
14. ☐ Skin Protection Protocol

DATE:	TIME:		
Physician Computer ID #	Physician SIGNATURE:	PRINT Physician NAME:	Beeper #:
Unit Secretary SIGNATURE:	TIME Sent to Pharmacy:	**RN SIGNATURE:**	

(Rev. 10/11/05)

ORDERS

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DIAGNOSIS: **ALLERGIES:**

15. Diet: ☐ Initiate Dysphagia Screening Protocol: diet and medication per screen results
Oral diet if screening passed: ☐ Prudent ☐ Diabetic , Prudent_____cal.
☐ Diabetic/ Calorie Controlled_____ cal. ☐ Other:_____

____Enteral feedings if screening failed:_____(Complete Adult Enteral Feeding Orders)

☐ Nutrition Consult
(Reason)_____

16. Labs: **Admission:** ☐ CBC with diff if not completed in ED ☐ CMP if not completed in ED
☐ PT/PTT if not completed in ED ☐ Homocysteine ☐ Fasting Lipid Profile (FLP)
Labs: **Daily:** ☐ PTT per Heparin Protocol
☐ PT Expanded daily X3 if on Warfarin (Coumadin®)

17. Labs: **Consider on Admission:**

☐ Magnesium if admission K+ abnormal
☐ ESR, RPR if no obvious cardiac source for cerebral ischemia
☐ Drug Screen if suspected abuse risk factors and no apparent stroke etiology
☐ TSH if arrhythmia suspected or increased cholesterol on FLP
☐ HgbA1C if increased glucose on CMP or history of diabetes mellitus
☐ Lupus inhibitor and anti- cardiolipin antibodies if PTT elevated
☐ Cardiac Profile (Troponin, CK(CPK)+ CK-MB) every 8 hrs. X3 if suspected cardiac ischemia
☐ ANA
☐ RF
☐ Thrombophilia Screen

18. Tests: ☐ EKG (if not completed in ED) Reason for Test: _____

19. Tests: ☐ CXR (PA/ Lateral) (if not completed in ED) Reason for Test: _____
☐ CXR (portable) (if not completed in ED) Reason for Test:_____

20. Diagnostic Tests: ☐ Carotid Ultrasound ☐ Transcranial Doppler ☐ Trans- Thoracic echocardiogram
☐ Trans-esophageal echocardiogram ☐ Cranial MRI without contrast
☐ Cranial MRI with and without contrast ☐ Intracranial MRA with contrast
☐ Carotid MRA with contrast ☐ MRV specify:_____
☐ Cerebral Arteriogram / CTA

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Chart Copy

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21. Respiratory: ☐ Nasal Cannula _____L/min.
☐ D/C oxygen if oxygen saturation sustained above 93% on room air
☐ Incentive Spirometry

22. Therapy: ☐PT Evaluate and Treat ☐ OT Evaluate and Treat ☐ Speech

23. ☐ Meets criteria for pneumococcal vaccine (ACIP Criteria on Infinet under "Guidelines")
☐ Administer 0.5ml. pneumococcal vaccine IM
☐ Meets criteria for Influenza vaccine (Sept.- Mar.) (ACIP Criteria on Infinet under"Guidelines")
☐ Administer 0.5 ml. influenza vaccine IM

24. Smoking Cessation Advice/ Counselling (if patient has smoked within the last year)
☐ Patient Education ☐ Nicotine Patch_____ (21mg/day or 14 mg./day or 7mg./day) patch top daily
☐ Bupropion SR_____ mg. (150 mg.) PO daily X3 days then bid

25. Medications (Select dose and route of administration):
☐ Enteric Coated Aspirin____ mg. (81mg. or 325 mg) PO daily **OR** Aspirin Suppository _____mg. (125mg or 300 mg.) PR daily if NPO
☐ Heparin sodium **(Complete STANDARD Adult Heparin Protocol Orders)**
☐ Warfarin (Coumadin®_____mg. (2 mg. or 5 mg.)PO/NG daily to start on second day of Heparin
☐ Ticlopidine (Ticlid®) 250 mg. PO/NG bid
☐ Clopidogrel bisulfate (Plavix®) 75mg. PO/NG daily
☐ Aspirin/ dipyridamole (Aggrenox ®)25/ 200 mg. PO bid
☐ Acetaminophen _____mg. (650mg.) PO/NG/PR every 6 hrs. prn mild discomfort
☐ Promethazine ____mg. (12.5 or 25 mg.) IV/PO/PR every 6 hrs. prn nausea-vomiting
☐ Aluminum –Magnesium Hydroxide(Maalox®) _____ml (30ml) PO/NG every 4 hrs. prn indigestion
☐ Lorazepam (Ativan®)_____mg. (0.5mg. or 1 mg.) PO/NG/IV every 8 hrs. prn anxiety
☐ Diphenhydramine hydrochloride (Benadryl®)____mg. (12.5 or 25 mg.) PO/NG/IV at bedtime prn sleeplessness

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25. Medications (Select dose and route of administration): Continued from page 3

Begin Statin, day 2, if indicated:

- ☐ Atorvastatin (Lipitor ®) _____mg every day
- ☐ Simvastatin (Zocor®) _____ mg daily in the evening
- ☐ Other _____
- ☐ Resume Home Medications as listed below (Include dose, route, and frequency)

_____

_____

_____

_____

26. DVT Prophylaxis: ☐ Heparin 5,000 units SQ bid
☐ Pneumatic compression devices to bilateral lower extremities

27. IV: Saline lock: flush per policy ☐ if on IV Heparin or IV medications greater than every 6 hrs., IV fluids_____
☐Other_____

Other:_____

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