FORM 13.13 (1/07)

13.13-1

THE UNIVERSITY OF CHICAGO HOSPITALS

PHYSICIAN ORDER FORM

PATIENT NUMBER

NAME-FIRST-LAST

NO. & STREET

CITY & STATE

CLINIC OR FLOOR | DATE

Physicians Please Note:

Each set of orders requires date, time, signature, beeper # and flagging.

One order per line. Number each individual order.

INITIAL orders require the following:

PRIMARY DX:______________________ ALLERGIES:

SECONDARY DX:______________________ DRUG ______________________

HT:__________ cm. WT:__________ kg. FOOD/LATEX ______________________

DATE & TIME	MUST ✓ IF MED.	MEDICATION ORDERS: (MUST include drug name, dose frequency, route and, if applicable, duration. USE OF GENERIC NAME IS ENCOURAGED. ANTIBIOTICS REQUIRE P, E OR T AND INDICATIONS FOR USE.) DIAGNOSTIC & TREATMENT: (MUST include indications for treatment/procedures.)	INDICATIONS	NURSING USE ONLY ORDER DISPATCHED SIGNATURE & MED. ADMIN. TIME

Acute Coronary Syndrome Order Set

Admit to: ☐ D5ICU ☐ 5SW ☐ 5SE ☐ Other_________ **Service:**______________________

Diagnosis:____

Allergies: ____

Attending: ______________________ **Resident:**______________________

Intern:______________________ **Intern Pager:**______________________

Referral Source: ☐ ED ☐ Clinic/physician ☐ Transfer from another facility

Routine RN Orders:

_____ Obtain weight upon admission and daily weight

_____ Vital Signs every _______ hours. Call house staff if SBP<90, HR <50, Temp> 101.0

_____ Telemetry monitoring

_____ Oxygen Therapy______________________________

_____ Check pulse oximeter, if 90% and chest pain free, discontinue oxygen. Notify MD if oximetry <90%

_____ Strict I&O

_____ FSBS every _______ hours

_____ Activity:______________________________

_____ Strict I&O

_____ Diet: ☐ NPO, except medications

☐ Cardiac (low cholesterol, 2-3 gram Na, low-fat, no caffeine)

☐ Diabetic__________calorie

☐ Other:______________________________

Laboratory:

_____ CPK, MB, Troponin ☐ every 6 hours ☐ every 8 hours First draw at ______________

_____ BMP, Mg, Phos, CBC, PT, PTT, LFT on ____/____/____ ____:_____ AM/PM

_____ CBC (with platelets), BMP, and Lipid profile in AM

Lab draw for: ☐ 6 AM Labs ☐ 10 AM Labs

☐ Fasting lab draw- Patient to remain NPO after 10 PM until AM lab draw

_____ C-Reactive protein on _____/____/_____ ____:_______ AM/PM

_____ Other:____

EKG:

_____ 12 Lead ECG in AM and STAT for complaints of chest pain

MD Signature______________________________ Pager______________

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Medication Orders:

Antiplatelet Therapy (STEMI/ NSTEMI) ****Response Required****

First dose Aspirin (325 mg PO) ☐ Given in ED ☐ Given by EMS ☐ Taken at home prior to arrival

If not administered:

_______ Aspirin 325 mg PO **STAT**

_______ Aspirin _____ mg PO everyday

Contraindications to Aspirin Therapy: ***Must select one of the following if Aspirin not administered*

☐ Active bleeding on arrival or within 24 hours after arrival ☐ Aspirin Allergy

☐ Coumadin/ Warfarin as pre-arrival medication

☐ Other reason (please list):________________________

Clopidogrel

_______ Clopidogrel (Plavix) _____ mg PO every _____ **Start dose on**: ______________

_______ Other dosing regimen: ____

Beta Blockers **STEMI/NSTEMI** ****Response Required****

_______ Metoprolol (Lopressor) 5 mg IVP; repeat every 5-15 minutes × 2 doses- **STAT**

_______ Metoprolol (Lopressor) ______ mg PO every _______

_______ Metoprolol (Toprol XL) ______ mg PO every _______

_______ Carvedilol (Coreg) _______ mg PO BID

_______ Other: ____

***** Must select one of the following if Beta Blocker not administered:***

☐ Severe Bradycardia ☐ Decompensated Heart failure ☐ Hypotension/ Shock

☐ Bronchospastic Disease ☐ Advanced Heart Block

☐ Drug-induced coronary spasm ☐ Other (please list):______________________________

Ace Inhibitors **STEMI/NSTEMI** ****Response Required****

LV ejection fraction: ______% As measured by: ☐ Echo ☐ Cardiac Catheterization

☐ Previous Documentation ☐ Not Measured **(Evaluation indicated prior to discharge)**

______ Captopril (Capoten) _____ mg (6.25-50 mg) PO every______ hours. ***First Dose on***:_________

______ Other: ____ ***First Dose on***:_________

*****Must select one of the following contraindications if Ace Inhibitor not administered:***

☐ ACEI or ARB allergy ☐ Moderate to severe aortic stenosis ☐ hypotension

☐ Serum Creatinine> 3 mg/dl ☐ Bilateral renal stenosis ☐ Elevated serum potassium

☐ Angioedema ☐ Pregnancy ☐ Titrating Beta Blockers

☐ Not Indicated ☐ Other (Please list):____

MD Signature____ Pager________________

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Angiotensin Receptor Blocker (ARB) **STEMI/NSTEMI** ****Response Required****

_______ Valsartan (Diovan) ________mg PO every __________. ***First dose on:*** ________________

_______ Losartan (Cozaar) ________ mg PO every _________. ***First dose on:*** ________________

_______ Other: ____

****Must select one of the following contraindications if Angiotensin Receptor Blocker not administered:**

☐ ACEI or ARB allergy ☐ Bilateral renal artery stenosis ☐ Pregnancy ☐ Not indicated

☐ Other, please specify____

Nitroglycerin

_______ Start **Nitroglycerin IV 100 mg/ 500 ml** solution at ____ mcg/min STAT

☐ RN May titrate up to chest pain/ BP (ICU Only)

☐ MD to titrate Nitroglycerin IV on telemetry and step down units

☐ Hold for symptomatic hypotension

______ D/C IV nitroglycerin at 6 AM next day

______ **Nitroglycerin** 0.4 mg SL/ spray every 5 minutes PRN for chest pain.

(Repeat every 5 minutes × 2 doses. Notify MD if chest pain persists.

______ **Nitroglycerin** ointment _____ inch to chest wall every _____ hours ☐ remove at bedtime

☐ ***Call MD/NP for chest pain or a SBP >150 mm Hg or <90 mm Hg***

GP IIb-IIIa Inhibitors

**Refer to UCH formulary for renal dosing recommendations in patients with creatinine ≥ 1.5 mg/dl

Eptifibatide (Integrilin):

_____ Eptifibatide (Integrilin) Bolus Dose _________

_____ Eptifibatide (Integrilin) 200 mg/ 100 mL solution: ____ mcg/kg/min × _______ hours (***Up to 72 hours***)

Discontinue infusion on ____________ (Date/Time)

Tirofiban (Aggrastat):

____ Tirofiban (Aggrastat) Bolus Dose _________

____ Tirofiban (Aggrastat) 12.5 mg/ 250 mL solution: _____mcg/kg/minute × _______ hours

Discontinue infusion on ____________ (Date/Time)

Heparin **STEMI/NSTEMI**

Unfractionated Heparin:

______ Bolus:_______ units IVP ☐ Bolus administered in ED

______ Then infusion: _______ units/ hour

______ PTT level to be drawn **6 hours** after heparin started

______ Discontinue Heparin infusion at: ______________________

Low-Molecular Weight Heparin:

_______ Enoxaprin (Lovenox) _____ mg (1 mg/kg rounded to the nearest 10 mg SQ every 12 hours)

_______ Other:____

☐ **Hold AM dose of LMWH if scheduled for cardiac catheterization or invasive procedures**

MD Signature____ Pager_______________

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DRUG ____

FOOD/LATEX ____

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Statins **STEMI/NSTEMI** ****Response Required****

_______ Atorvastin (Lipitor) ______ mg PO qHS
_______ Simvastatin (Zocor) ______ mg PO qHS
_______ Other:____

****Must select one of the following if statin not administered:**

☐ Allergy related ☐ History of myopathy
☐ Moderate LFT elevation (AST/ALT greater than 3 times upper limit of normal)
☐ Other, specify:____

Smoking Cessation **STEMI/NSTEMI** ****Response Required****

_____ No history of smoking
_____ Positive history of smoking cigarettes during the one year prior to hospital arrival
_____ Consult: UC Asthma Center's Tobacco Control Program-
Nursing staff/ PSE- To initiate consult, *****Fax Page (4) of this order set with patient label 2-4736***
Date & Time Consult Faxed:_______________
_____ Provide patient with UCH Smoking Cessation Brochure

☐ Patient offered, but refused smoking cessation counseling

Nicotine Replacement Medications

_____ Nicoderm patch ______ mg (standard dose 7 mg/ 14 mg/ 21 mg) transdermal daily
_____ Bupropion (Zyban) 150 mg everyday × 3 days, then 150 mg PO BID
_____ Bupropion (Wellbutrin SR) _______ mg PO ________
**May use in conjunction with nicotine replacement*

Cardiac Rehabilitation

_____ Consult case management for Cardiac Rehabilitation *(Phase I)* following hospital discharge.
****Call consult to case management with department info, patient ID, and room number***

Other Orders

MD Signature____ Pager________________

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