

MCG Health, Inc.
Admission Orders for General Internal Medicine

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USE STANDARD OrderComm Orders Header & footer

Condition:	<input type="checkbox"/> Stable	<input type="checkbox"/> Unstable	<input type="checkbox"/> Guarded	<input type="checkbox"/> Terminal
Admit to:	<input type="checkbox"/> Observation	<input type="checkbox"/> Medicine Floor	<input type="checkbox"/> Telemetry	
Type of Admission:	<input checked="" type="checkbox"/> Regular	<input type="checkbox"/> Observation		
Admitting Diagnosis:				
Anticipated discharge date:				
Allergy status:				
Advanced Directives:	<input type="checkbox"/> Full Code	<input type="checkbox"/> Do Not Resuscitate	<input type="checkbox"/> Do Not Intubate	<input type="checkbox"/> Comfort Measures Only
Proxy/Family Contact:	Name:		Telephone:	
Special Precautions:	<input type="checkbox"/> Respiratory Failure	<input type="checkbox"/> Falls	<input type="checkbox"/> Delirium	<input type="checkbox"/> Suicide <input type="checkbox"/> Other: _____
Vital Signs:	<input type="checkbox"/> Every 4 hours	<input type="checkbox"/> Every 8 hours	<input type="checkbox"/> Other _____	
Neuro checks q _____				
Isolation and precautions:	<input type="checkbox"/> Airborne (TB, Influenza, meningitis)	<input type="checkbox"/> Droplet	<input type="checkbox"/> Contact (MRSA, C.diff, VRE)	<input type="checkbox"/> Neutropenic precautions
Oxygen assessment:	<input type="checkbox"/> O2 sat check with vital signs	<input type="checkbox"/> q4 h	<input type="checkbox"/> q8h	<input type="checkbox"/> other _____
Activity:	<input type="checkbox"/> As tolerated	<input type="checkbox"/> Bed rest	<input type="checkbox"/> Up in chair	<input type="checkbox"/> Out of bed with assistance <input checked="" type="checkbox"/> Bathroom privileges
Diet:	<input type="checkbox"/> NPO	<input type="checkbox"/> NPO except medications	<input type="checkbox"/> Regular	<input type="checkbox"/> Other
<input type="checkbox"/> Strict I+O				
<input checked="" type="checkbox"/> Weigh Patient Daily				
<input type="checkbox"/> Place NG tube <input checked="" type="checkbox"/> clamped <input type="checkbox"/> low constant suction <input type="checkbox"/> low intermittent suction <input type="checkbox"/> use for meds				
Route: _____ Type: _____ <input type="checkbox"/> Bolus Volume: _____ Every _____ hours				
<input type="checkbox"/> Enteral feeding: <input checked="" type="checkbox"/> continuous at _____ mL/hour				
<input type="checkbox"/> flush every _____ <input type="checkbox"/> check for residuals every _____ <input type="checkbox"/> if residual > _____ mL hold feeding				
IV fluids: _____ at _____ mL/hour intravenously				
Immunizations: Influenza (October to February) and Pneumococcal vaccine will be provided to patients for whom the immunizations are indicated per medical staff approved standing orders				

Physician Signature: _____ Title: _____
Printed Name: _____ Date: _____

Medications

- Venous Thromboembolism/DVT prophylaxis, see separate VTE prevention protocol
- Supplemental Insulin Protocol for Non-Pregnant Type 2 Diabetic Patients (separate orders)
- Alcohol Withdrawal Prevention Protocol (separate orders)
- Delirium Prevention:

PRN Medications:

- Acetaminophen 650 mg PO every 4 hours for pain or headache
- Aluminum hydroxide/ Magnesium hydroxide suspension (Maalox) 30 ml PO every 4 hours as needed for dyspepsia
- Albuterol MDI with spacer 2 puffs PRN wheezing
- Ipratropium MDI with spacer 2 puffs PRN wheezing
- Bisacodyl (Dulcolax) 5 mg PO at bedtime as needed for constipation
- Zolpidem 5 mg PO QHS PRN insomnia

Physician Signature: _____ Title: _____
Printed Name: _____ Date: _____

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<u>Call physician when:</u>	<u>Greater than:</u>	<u>Less than:</u>	<u>(Suggested Parameters)</u>
Systolic BP			> 180 or < 90
Diastolic BP			> 100 or < 40
Heart rate			> 120 or < 45 beats/min
Respiratory rate			> 30 breaths/min
Temperature			> 38.5 degrees C
Oxygen saturation			< 90 %
Glucose			> 400 or < 50 mg/dL

Telemetry Parameters: Call physician for change in rhythm from baseline, e.g. > 6 PVC's, new atrial fibrillation or ventricular tachycardia	
Skin decubitus prophylaxis <input type="checkbox"/> per protocol <input type="checkbox"/> Other:	
Aspiration precautions: <input type="checkbox"/> Elevated bed 45 degrees	
<input type="checkbox"/>	
Consults:	
<input type="checkbox"/> Physical Therapy	Indication:
<input type="checkbox"/> Occupational Therapy	Indication:
<input type="checkbox"/> Speech Therapy (swallowing)	Indication:
<input type="checkbox"/> Respiratory Therapy	Indication:
<input type="checkbox"/> Dietician	Indication:
<input type="checkbox"/> Nursing wound care	Indication:
<input type="checkbox"/> Smoking cessation	Indication:
<input type="checkbox"/> Discharge planning	Indication:
Laboratory:	
Radiology (must use separate Radiology order forms) orders attached <input type="checkbox"/> yes <input type="checkbox"/> no orders	

Physician Signature: _____ Title: _____
Printed Name: _____ Date: _____