

Aurora BayCare Medical Center



ABMC Unacceptable Abbreviations:

U, u or IU cc µg TIW
 qid qod gr or dr qd
 MgSO4 MSO4 MS
 AS AD AU
 OS OD OU

STAT

Cannot use trailing Zero, Must use leading Zero

Patient Label

Use Ball Point Pen Only

Patient Weight: _____ kg **Diabetic:** Yes No **Allergies:** _____

DATE	TIME	PHYSICIAN ORDERS
		ACUTE STROKE (Ischemic / Hemorrhagic) OR Transient Ischemic Attack (TIA) ADMISSION ORDERS
		Orders that are pre-checked will be implemented.
		If patient is current patient, use BC-1215 "Acute Stroke-Emergency Eval and Treatment"
		<input checked="" type="checkbox"/> Admit as inpatient to: <input type="checkbox"/> ICU 3: Stroke Unit -(Circle) eICU Level 1 or 2 <input type="checkbox"/> IMCU <input type="checkbox"/> Med-Surg
		<input checked="" type="checkbox"/> Diagnosis: <input type="checkbox"/> Acute Ischemic Stroke <input type="checkbox"/> Acute Hemorrhagic Stroke
		<input checked="" type="checkbox"/> Code status: <input type="checkbox"/> FULL CODE <input type="checkbox"/> NO CODE <input type="checkbox"/> Other: _____
		<input checked="" type="checkbox"/> Condition: _____
		<input checked="" type="checkbox"/> Admitting Physician: _____ Attending Physician: _____
		<input checked="" type="checkbox"/> Previous Medical Record to unit, if applicable
		<input type="checkbox"/> Ischemic stroke: All items in black box will be implemented
		<input type="checkbox"/> Hemorrhagic stroke: Only items below dotted black line will be implemented
		<input checked="" type="checkbox"/> DVT Prophylaxis (hold x 24 hrs if patient received thrombolytic agent)
		<input type="checkbox"/> Enoxaparin 40 mg SQ daily (If Creatinine clearance < 30 mL/min, pharmacy to dose)
		<input checked="" type="checkbox"/> Antithrombotics (hold x 24 hrs if patient received thrombolytic agent)
		<input type="checkbox"/> Aspirin 81 mg (Circle route) PO/NG/rectum daily
		<input type="checkbox"/> Aspirin 325 mg (Circle route) PO/NG/rectum daily
		<input type="checkbox"/> Clopidogrel 75 mg PO/NG daily (Pharmacy may substitute ticlodipine if patient allergic)
		<input type="checkbox"/> Aspirin/Dipyridamole 25/200 1 capsule PO BID or _____
		<input checked="" type="checkbox"/> NIH Stroke Scale assessments: upon admission to unit, 1 hour post thrombolytic (if given), prior to discharge, and PRN for worsening symptoms
		Items below this line apply for diagnosis of Ischemic AND hemorrhagic stroke
	
		<input checked="" type="checkbox"/> Lipid profile in AM
		<input checked="" type="checkbox"/> Dysphagia screen <input type="checkbox"/> Done in ED passed / failed (circle one)
		<input type="checkbox"/> Swallow evaluation (Video Fluoroscopy) by Speech Therapy
		<input type="checkbox"/> Give patient sip of water. If no choking, start diet on page 3. If patient has choking, make patient NPO and consult Speech Therapy for formal evaluation.
		<input checked="" type="checkbox"/> Stroke Education: Give patient/family the Stroke Education binder and document
		<input checked="" type="checkbox"/> Activate referral trigger to RT for smoking cessation counseling if current smoker or quit < 12mo.
		<input checked="" type="checkbox"/> Notify Care Management (X 4238) of admission so they may follow
		<input checked="" type="checkbox"/> DVT Prophylaxis: Sequential Compression Devices - Thigh length / Knee length (circle one)



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Table with columns: DATE, TIME, PHYSICIAN ORDERS. Contains sections for ACUTE STROKE, BLOOD PRESSURE CONTROL, and various medication orders with checkboxes.



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		<input type="checkbox"/> Ischemic stroke patient: <i>NOT treated with thrombolytic</i>: Complete 1-3 below:
		1. Assess vital signs and neuro checks q 4h x 24 h, then q 8h x 24 h, then B.I.D.
		2. If SBP >220 mmHg or > _____ mmHg OR DBP 121-140 mmHg or _____ mmHg
		<input type="checkbox"/> Labetalol 10 mg IV over 1-2 minutes. May repeat or double every 10-20 Minutes to a maximum dose of 300 mg.
		<input type="checkbox"/> Nicardipine drip 5 mg/hour as initial dose; titrate to keep SBP <180 or DBP <105, may increase by 2.5 mg/hour q 5 minutes to maximum of 15 mg/hr
		3. Emergency antihypertensive therapy is deferred (for SBP < 220 or DBP < 120) unless indicated due to the presence of: aortic dissection, acute myocardial infarction, severe CHF or hypertensive encephalopathy. If indicated: treat SBL > _____ or DBP > _____ with _____
		<input type="checkbox"/> Hemorrhagic stroke patient: Complete 1-2 below:
		1. Assess vital signs and neuro checks q 15 minutes until stable, then q 1 hour x 6 hours, then 4 hours x 24 hours, then q 8 hours x 24 hours, then B.I.D.
		2. <input type="checkbox"/> Sodium nitroprusside drip to keep SBP < _____
		<input type="checkbox"/> Other: _____
		For All Stroke Patients: Complete remainder of pages 3 and 4:
		<input type="checkbox"/> Telemetry monitor
		<input checked="" type="checkbox"/> Activity: <input type="checkbox"/> Complete Bedrest <input type="checkbox"/> Bathroom Privileges only <input type="checkbox"/> Up as tolerated
		<input checked="" type="checkbox"/> Pressure reducing mattress as indicated by Braden assessment
		<input checked="" type="checkbox"/> Diet: <input type="checkbox"/> NPO <input type="checkbox"/> Per Speech Therapy evaluation
		<input type="checkbox"/> _____
		<input checked="" type="checkbox"/> I & O
		<input checked="" type="checkbox"/> Foley catheter PRN if unable to void / bladder distention
		<input checked="" type="checkbox"/> IV access: <input type="checkbox"/> IV fluids _____ at _____ mL/hr
		<input type="checkbox"/> Saline lock
		<input checked="" type="checkbox"/> Labs: <input type="checkbox"/> Bedside blood sugar 4 times per day x 48 hours or _____
		<input type="checkbox"/> CBC, CMP, PT/INR (if not previously done)
		<input type="checkbox"/> 12 lead EKG, CXR (if not previously done)
		<input type="checkbox"/> Daily weight
		<input type="checkbox"/> Begin O2 at _____ liters/minute and RT to evaluate and titrate O2 to keep sats > _____ %
		<input type="checkbox"/> Carotid Doppler study



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		<input type="checkbox"/> Echocardiogram: <input type="checkbox"/> transthoracic <input type="checkbox"/> transesophageal
		<input type="checkbox"/> MRI – Brain: With / Without contrast (circle one)
		<input type="checkbox"/> MRA – Carotids / Head (circle one)
		<input type="checkbox"/> CT angiogram of head / carotids (circle one)
		<input type="checkbox"/> Transcranial Doppler
		<input checked="" type="checkbox"/> If blood sugar < 70, give 25 mL D50% IV.
		<input checked="" type="checkbox"/> If blood sugar < 45, give 50 mL D50% IV and notify physician immediately
		<input checked="" type="checkbox"/> If blood sugar > 300, notify physician immediately
		<input type="checkbox"/> Other glucose control orders:
		<input checked="" type="checkbox"/> Meds:
		<input type="checkbox"/> Continue home medications per home medication list
		<input type="checkbox"/> Contact admitting physician for home medications
		<input type="checkbox"/> Acetaminophen 650 mg PO / per nasogastric tube / per rectum (circle one)
		Q 4 hr PRN for temp > 99.5 F or pain. Notify physician if temp > 101.
		<input type="checkbox"/> Docusate sodium 100 mg PO / per nasogastric tube (circle one) BID
		<input type="checkbox"/> Senna 2 tablets PO daily
		<input type="checkbox"/> Pravastatin 20 mg PO daily at HS
		<input type="checkbox"/> _____ mg PO daily at HS
		CONSULTS:
		<input type="checkbox"/> Acute Rehab Team <input type="checkbox"/> Social Services
		<input type="checkbox"/> Nutrition Services <input type="checkbox"/> Speech Therapy
		<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy
		<input type="checkbox"/> Neurology consult with Dr. _____ <input type="checkbox"/> STAT <input type="checkbox"/> Routine
		<input type="checkbox"/> Neurosurgery consult with Dr. _____ <input type="checkbox"/> STAT <input type="checkbox"/> Routine
		<input type="checkbox"/> Hospitalist / Intensivist consult (circle one) <input type="checkbox"/> STAT <input type="checkbox"/> Routine
		<input type="checkbox"/> Pastoral Care <input type="checkbox"/> Now <input type="checkbox"/> Routine
		<input type="checkbox"/> Neuropsychology

Physician Signature: _____ **Date** _____ **Time:** _____



PPO 00003679
PHYSICIAN ORDERS