## Physician Orders

**LEB Post DKA Routine Care Phase**

[X or R] = will be ordered unless marked out.

<table>
<thead>
<tr>
<th>Height: cm</th>
<th>Weight: kg</th>
</tr>
</thead>
</table>

### Admission/Transfer/Discharge

- **Patient Status Initial Inpatient**
  - Attending Physician:

- **Bed Type:** [ ] Med Surg [ ] Critical Care [ ] Stepdown [ ] Other

#### Initial Status - Inpatient
- For a condition/dx with severity of illness or co-morbid conditions indicating a hospital stay greater than 24 hours is required.
  - Routine recovery after outpatient surgery is estimated at 6-8 hours.
  - "Extended" routine recovery may be required for a patient to stay longer (could be overnight) to recover from anticipated sequela of surgery including effects of anesthesia, nausea, pain.
  - For unanticipated sequela of surgery or a complicated post operative course, the patient may require a status change to inpatient. Please consult with a case manager before making this choice of "status change".
  - Examples: Initial status outpatient is generally selected for patients undergoing PCI, diagnostic caths, EP studies, ablations, pacemaker implantations, other routine surgeries.

- **Initial Status Outpatient - Observation Services**
  - Short term treatment, assessment and reassessment - estimate discharge within 24 hours
  - In some cases (for Medicare patients), this can be extended to 48 hours.
  - Observation Services can also be utilized when it is unclear (without additional assessment) whether the patient will require an inpatient stay.

#### Vital Signs

- **Vital Signs**
  - Monitor and Record T,P,R,BP, routine per unit
  - Routine Monitor and Record T,P,R,BP, q4h(std)

#### Activity

- **Out Of Bed**
  - Up Ad Lib

#### Patient Care

- **Advance Diet As Tolerated**
  - Start clear liquids and advance as tolerated to ADA Diet
  - Pediatric________ calories

- **Isolation Precautions**
  - Isolation Type: ____________________

- **Intake and Output Strict**
  - Routine, q2h(std), per routine

- **Whole Blood Glucose Nsg (Bedside Glucose Nsg)**
  - Routine, ACHS and 0200

- **Whole Blood Glucose Nsg (Bedside Glucose Nsg)**
  - Routine, ACHS

- **LEB Hypoglycemia Protocol Plan**
  - (see separate order sheet)

- **Daily Weights**
  - Routine, qEve

- **O2 Sat Spot Check-NSG**
  - With vital signs

- **O2 Sat Monitoring NSG**
  - T;N

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**LEB ENDO Post DKA PO Trial of Post DKA**

Greater than 3 Years of Age-42505-PP-QM0910

Rev121913
**Physician Orders**

**LEB Post DKA Routine Care Phase**

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- **Instruct/Educate**
  - T;N, Who: Patient and family, Sick day rules and use of Diabetes pager.
  - T;N, Who: ___________________.

- **Nursing Communication**
  - T;N, Upon initiation of the LEB Post DKA 3 Yrs and GREATER THAN **Routine Care phase**, Nursing to discontinue LEB DKA Admit Plan.
  - T;N, Target blood sugar range 80 to 150 mg/dL
  - T;N, If bedside glucose is less than 70 mg/dL or greater than 500 mg/dL, place order for STAT serum glucose.
  - T;N, If blood glucose greater than 240 mg/dL, place order for STAT Ketones Urine.

- **Supply to Bedside**
  - T;N, place home supplies for urine ketone and blood sugar testing at bedside for diabetic education

- **Oxygen Delivery**
  - T; N, _____L/min, Titrate to keep O2 sat =/> 92% Wean to room air

### Respiratory Care

- **LEB Convert IV to INT/ Hepwell Plan**
  - see separate sheet

### Medications

- **acetaminophen**
  - _____mg(10 mg/kg), Liq, PO, q4h, PRN, Pain or Fever, T;N, Max Dose = 90mg/kg/day up to 4 g/day
  - 80 mg, chew tab, PO, q4h, PRN, Pain or Fever, T;N, Max Dose = 90 mg/kg/day up to 4 g/day
  - 325mg, tab, PO, q4h, PRN, Pain or Fever, T;N, Max Dose = 90 mg/kg/day up to 4 g/day
  - _____ _ mg(10 mg/kg), Supp, PR, q4h, PRN, Pain or Fever, T;N, Max Dose = 90mg/kg/day up to 4 g/day

- **glucagon**
  - 1 mg, Injection, Subcutaneous, PRN, Hypoglycemic seizure, routine, T;N

- **ketostix**
  - 1 each, strip, test, N/A, routine, T;N, Available for diabetes education
**Physician Orders**

**LEB Post DKA Routine Care Phase**

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### Laboratory

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Metabolic Panel (BMP)</td>
<td>T;N, Routine, once, Type: Blood</td>
</tr>
<tr>
<td>Potassium Level</td>
<td>T;N, Routine, once, Type: Blood</td>
</tr>
<tr>
<td>Sodium Level</td>
<td>T;N, Routine, once, Type: Blood</td>
</tr>
<tr>
<td>Vitamin D 25 Hydroxy</td>
<td>T;N, Routine, once, Type: Blood</td>
</tr>
<tr>
<td>Islet Cell Antibody Orders Plan</td>
<td>see separate sheet</td>
</tr>
</tbody>
</table>

### Nursing Communication

<table>
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<tr>
<td>LEB Convert IV to INT/ Hepwell Plan</td>
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<td>LEB Hypoglycemia Protocol Plan</td>
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### Consults/Notifications

<table>
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<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notify Resident-Continuing</td>
<td>T;N, For: All Blood Sugar Results, Who: Care Team D</td>
</tr>
<tr>
<td>Notify Resident-One Time</td>
<td>T;N, Consult Who: ____________________, Who: ____________________</td>
</tr>
<tr>
<td>Consult MD Group</td>
<td>T;N, Consult Who: ____________________, Reason: ________________</td>
</tr>
<tr>
<td>Consult MD Group</td>
<td>T;N, Consult Who: ____________________, Reason: New onset Diabetes</td>
</tr>
<tr>
<td>Consult MD</td>
<td>T;N, Consult Who: ____________________, Reason: New onset Diabetes</td>
</tr>
<tr>
<td>Consult Medical Social Work</td>
<td>T;N, Routine, Reason________________________________________________________________________</td>
</tr>
<tr>
<td>Consult Case Management</td>
<td>T;N, Reason________________________________________________________________________________</td>
</tr>
<tr>
<td>Diabetic Teaching Consult</td>
<td>T;N, Reason: New Onset Diabetes-Survival Skills</td>
</tr>
<tr>
<td>Dietitian Consult</td>
<td>T;N, Type of Consult: Education</td>
</tr>
</tbody>
</table>

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**Date**  
**Time**  
**Physician's Signature**  
**MD Number**