Physician Orders ADULT: Hematuria Admit Plan

Initiate Orders Phase
Care Sets/Protocols/PowerPlans
☐ Initiate Powerplan Phase
   Phase: Hematuria Admit Phase, When to Initiate:__________________________

Hematuria Admit Phase
Admission/Transfer/Discharge
☐ Patient Status Initial Inpatient
   T;N Admitting Physician: ________________________________________________
   Reason for Visit: _______________________________________________________  
   Bed Type: __________________ Specific Unit: ________________________________
   Care Team: _____________________________________________________________
   Anticipated LOS: 2 midnights or more

☐ Patient Status Initial Outpatient
   T;N, Attending Physician: ________________________________________________
   Reason for Visit: _______________________________________________________  
   Bed Type: __________________ Specific Unit: ________________________________
   Outpatient Status/Service OP-OBSERVATION Services

☐ Notify Physician-Once
   Notify For: room number upon arrival to unit

Vital Signs
☐ Vital Signs
   Monitor and Record T,P,R,BP, q4h(std)
☐ Vital Signs
   Monitor and Record T,P,R,BP, q8h(std)

Activity
☐ Bedrest w/BRP
☐ Out Of Bed
   Up As Tolerated
☐ Ambulate
   bid

Food/Nutrition
☐ NPO
☐ Regular Adult Diet
☐ Consistent Carbohydrate Diet
   Caloric Level: 1800 Calorie

Patient Care
☐ Irrigate
   Irrigate: bladder, Intermittent irrigation with Glycine
☐ I & O
Physician Orders ADULT: Hematuria Admit Plan

q8h(std)

Continuous Infusion
☐ Sodium Chloride 0.9%
   1,000 mL, IV, Routine, 100 mL/hr
☐ Sodium Chloride 0.45%
   1,000 mL, IV, Routine, 100 mL/hr
☐ Dextrose 5% in Lactated Ringers Injection
   1,000 mL, IV, Routine, 100 mL/hr
☐ LR
   1,000 mL, IV, Routine, 100 mL/hr
☐ Glycine
   3,000 mL, IRR Soln, IRR, Irrigation Site: Bladder, Titrate
   Comments: Continuous irrigation until no clots visible.

Medications
☐ +1 Hours amoxicillin-clavulanate 875 mg-125 mg oral tablet
   875 mg, Tab, PO, q12h, Routine
☐ +1 Hours cefTRIAXone
   1 g, IV Piggyback, IV Piggyback, q24h, Routine
☐ +1 Hours sulfamethoxazole-trimethoprim DS
   160 mg, DS Tab, PO, q12h, Routine, 160mg = 1 DS tab
☐ +1 Hours B & O Suppretttes 15-A
   1 supp, Supp, PR, q6h, PRN Bladder Spasm, Routine

Laboratory
☐ CBC
   Routine, T;N, once, Type: Blood
☐ CMP
   Routine, T;N, once, Type: Blood
☐ BMP
   Routine, T;N, once, Type: Blood
☐ PT
   Routine, T;N, once, Type: Blood
☐ PTT
   Routine, T;N, once, Type: Blood
☐ Type and Screen
   Routine, T;N, Type: Blood
☐ Transfuse PRBC’s - Not Actively Bleeding
   Routine, T;N
☐ Transfuse PRBC’s - Actively Bleeding

Attach patient label here
Physician Orders ADULT: Hematuria Admit Plan

*Report Legend:
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase, see separate sheet
R-required order

Routine, T;N
☐ Transfuse PRBC’s - MI/ACS/Symptomatic
                Routine, T;N
☐ Transfuse PRBC’s - Sickle Cell Disease
                Routine, T;N
☐ Hold PRBC
                Routine, T;N, Reason: Other (Specify in Special Instructions)
☐ Hct
                Routine, T+1;0400, once, Type: Blood
☐ Urinalysis
                Routine, T;N, once, Type: Urine, Nurse Collect
☐ Urinalysis w/Reflex Microscopic Exam
                Routine, T;N, once, Type: Urine, Nurse Collect
☐ Urine Culture
                Routine, T;N, Specimen Source: Urine Body Site: Bladder, Nurse Collect

Diagnostic Tests
☐ US Abd Comp
                T;N, Reason for Exam: Other, Enter in Comments, Other reason: Hematuria, Routine, Stretcher
☐ US Retroperitoneal B Scan/Real Time Comp
                T;N, Reason for Exam: Other, Enter in Comments, Other reason: Hematuria, Routine, Stretcher
☐ Pyelogram IV W/WO KUB W/WO Tomography
                T;N, Reason for Exam: Hematuria, Routine, Stretcher

Consults/Notifications/Referrals
☐ Consult MD

Date ____________________ Time ____________________ Physician’s Signature ____________________ MD Number ____________________

CC Hematuria Admit Plan 22211 QM1008 PP Rev062617   Page 3 of 3