

**INITIAL PHYSICIAN'S ORDERS**

768-22.11 (3-2008)

TO BE COMPLETED BY NURSING: **Ht.** **Wt.**

“Unless brand name of drug is circled, therapeutic substitution is authorized in accordance with P&T policy.”

DATE	TIME	ED Physician _____ Coordinated Care _____	Transcribed & Faxed By	Time
		<input type="checkbox"/> <b>Admit as Inpatient</b> <input type="checkbox"/> <b>Hold for Outpatient Observation</b> <b>Reason for Observation:</b> _____  Attending Physician _____ Dx: _____		
		<b>Unit:</b> <input type="checkbox"/> ICU/IMCU Cardiac protocol <input type="checkbox"/> ECCU Cardiac protocol <input type="checkbox"/> CCU/Cardiac Protocol <input type="checkbox"/> Medical/Surgical Unit <input type="checkbox"/> With Telemetry (Time limited order refer "Discontinuation of Telemetry Policy")		
		<b>Precautions:</b> <input type="checkbox"/> Initiate Isolation Measures <input type="checkbox"/> Airborne <input type="checkbox"/> Respiratory /Droplet <input type="checkbox"/> Contact <input type="checkbox"/> Neutropenic		
		<b>Vital Signs:</b> <input type="checkbox"/> Q shift <input type="checkbox"/> Q 4 hours <input type="checkbox"/> Q _____ hours <input type="checkbox"/> Neuro ✓'s Q _____ hours <input type="checkbox"/> Other: _____		
		<b>Activity:</b> <input checked="" type="checkbox"/> Ambulate unless otherwise ordered <input type="checkbox"/> Other: _____		
		<b>Diet:</b> <input type="checkbox"/> Regular <input type="checkbox"/> NAS <input type="checkbox"/> Cardiac <input type="checkbox"/> _____ Cal <input type="checkbox"/> Full liquid <input type="checkbox"/> Clear liquid <input type="checkbox"/> NPO <input type="checkbox"/> Other: _____		
		<b>Teaching:</b> <input checked="" type="checkbox"/> Provide Smoking cessation counseling/brochure (if smoked in the last 12 months)		
		<b>Allergies:</b> _____		
		<b>Consults:</b> _____		
		<b>Labs:</b> _____		
		<b>Diagnostics Tests:</b> _____		
		<b>IV:</b> _____		
		<input type="checkbox"/> <b>See signed Medication Reconciliation Form for Additional Medication Orders</b> <b>Medications</b> _____ _____ _____		
		<b>Vaccines:</b> <input checked="" type="checkbox"/> Administer <u>Pneumococcal Vaccine</u> 0.5 mL IM deltoid during inpatient stay within 48 hours of admission <input type="checkbox"/> Omit ( <b>Document reason for omission in Progress Note</b> ) <input checked="" type="checkbox"/> Administer <u>Flu Vaccine</u> 0.5 mL IM deltoid during inpatient stay within 48 hours of admission (October to March) <input type="checkbox"/> Omit ( <b>Document reason for omission in Progress Note</b> )		
		_____ _____ _____		
		<b>Physician's Signature:</b> _____		

**Nursing Protocol for Polysaccharide Pneumococcal Vaccine administration:**

1. If vaccine ordered, assess temperature prior to vaccination. If > 101 degrees F/38.3C Core or > 100 degreesF/37.7C orally, hold dose and recheck temperature every 24 hours until less than the above values, then administer vaccine.

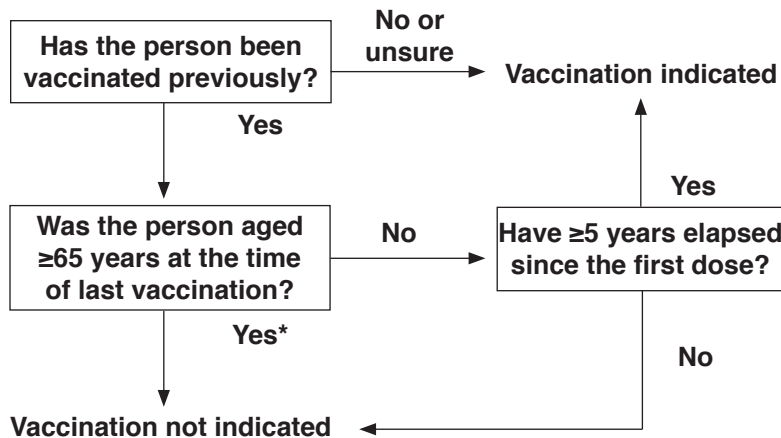
2. Before administering vaccine, assess if patient has previously received vaccine - if yes, When \_\_\_\_\_ . One-time revaccination is indicated **ONLY** if:

(a). Age 3-65 and at high risk for pneumococcal infection (immunocompromised - see Guidelines) and prior vaccine > 5 years ago, **OR**

(b). Age > 65 and prior vaccination > 5 years ago and were < 65 at initial vaccination

**COMPLETE THIS SECTION FOR ORDER OMISSION(S)**

FIGURE 1. Algorithm for vaccinating persons aged  $\geq 65$  years



\*Note: For any person who has received a dose of pneumococcal vaccine at age  $\geq 65$  years, revaccination is not indicated.

**Admit as Inpatient:** Acute inpatient hospital level of care must be medically necessary and appropriate for the diagnosis, condition and treatment of the patient. The patient must demonstrate signs and/or symptoms severe enough to warrant intensive medical care and must receive care of such complexity that they can only be rendered safely and effectively on an inpatient basis. Hospitalization is expected to be more than 24 hours OR admission is for hospice, respite or nursing home placement.

**Hold for Observation:** "Observation Services" are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to evaluate a patient's condition to determine the need for possible admission to the hospital as an inpatient, the duration of such service is not to exceed one day.