Suspected Appendicitis Admission Orders (Ward/Stepdown)

Admit to:	**Unit/Ward:**	☐ **Telemetry**
MD/NP/PA:	**Pager No.: ( )**	**Change of Service/Team as of:**
MD/NP/PA:	**Pager No.: ( )**	______/______/______**Time:**____________
Sr. Resident:	**Pager No.: ( )**	
Attending MD:	**Pager No.: ( )**	**To:** ________________________________

Diagnosis:	**Appendicitis**	**Condition:** ☐ Good ☐ Fair ☐ Serious ☐ Critical
Allergies:	☐ NKDA ☐ Allergies/specify reactions:	
Assessment:	☑ Vital signs: ☐ Per unit protocol ☐ Q_____hrs ☐ O2 saturation: ☐ Per unit protocol ☐ Q_____hrs ☐ Isolation:________________________________ ☐ Precautions: ☐ Fall ☐ Seizure ☐ Aspiration	☐ Record strict input and output Qshift ☐ Obtain old chart ☐ Other: ☐ Other:
Physician Notification: *Notify provider for any of the following*	☑ Systolic BP less than 80 or greater than 160 mmHg ☑ Diastolic BP less than 45 or greater than 100 mmHg ☑ Temp greater than 38.0°C (103° F) ☑ Severe pain not relieved by medication (pain 7 or greater on a scale of 0-10)	☑ Pulse less than 50 or greater than 120 BPM ☑ Resp. rate less than 10 or greater than 30 ☑ Urinary output: less than 240 mL within 8 hrs ☐ O2 saturation less than 90% ☐ Other:
Activity:	☐ Ad lib ☐ Bed rest with bathroom privileges ☐ Strict bed rest	☐ Head of bed up 30° ☐ Other: ☐ Other
Diet:	☐ Strict NPO	☐ Other:
Treatment:	☐ IV ________________________at _______mL per hr ☐ IV NS 500 mL bolus Once	☐ Foley catheter to gravity ☐ Other:
Labs/Tests: ☐ Stat ☐ Next phlebotomy	☐ INR/PT ☐ PTT ☐ Urine pregnancy test ☐ Chest x-ray: Pre-Op	☐ EKG ☐ Other:

DVT Prophylaxis:

☐ DVT prophylaxis not indicated due to:____

☐ Risk assessment completed: pharmacologic prophylaxis risk outweighs benefit

☐ Sequential compression device

☐ Other:

Comfort Meds: (Do not exceed 6 mg IVP morphine per dose)

☐ Morphine ______ mg Q________ hrs PRN moderate (4-6) pain Choose one route: ☐ IVP ☐ Subcut	☐ Metoclopramide [REGLAN] 10 mg IVPB Q6 hrs PRN nausea or vomiting
☐ Morphine _________ mg Q____ hrs PRN severe (7-10) pain Choose one route: ☐ IVP ☐ Subcut	☐ Diphenhydramine [BENADRYL] 25 mg IVP Nightly PRN itchiness or insomnia
☐ Famotidine [PEPCID] 20 mg IVPB BID	☐ Other:
☐ Famotidine [PEPCID] 20 mg IVPB Daily (CrCl less than 50 mL per min)	

Antibiotic:

☐ Cefotetan [CEFOTAN] ☐ 1 gm IVPB Q 12 hrs

Provider Last Name (Print):		
Provider Signature:	ID#:	
Date: / /	Time: :	AM / PM
RN Last Name (Print):		
RN Signature:	Initials:	
Date: / /	Time: :	AM / PM
Clerk/LVN Signature:	Initials:	
Date: / /	Time: :	AM / PM

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Suspected Appendicitis DVT Risk Assessment and Prophylaxis Tool

Relative Contraindications to Sequential Compression Device (SCD)	**Risk Factors** 1 point each, unless otherwise noted Quantify risk score and see "DVT Prophylaxis" below
☐ Acute superficial or deep vein thrombosis ☐ CHF (class III or IV) ☐ Severe peripheral artery disease	**Stasis** ☐ Acute COPD exacerbation ☐ Acute MI ☐ Age 40 years or greater ☐ Anticipated immobilization/bed confinement greater than 24 hours ☐ CHF (class III or IV) **(3 points)** ☐ Hemi-, para-, or quadraparesis **(3 points)** ☐ Hospital or nursing facility stay within 90 days **(3 points)** ☐ Mechanical ventilation **(3 points)** ☐ Obesity (BMI 30 kg/m^2 or greater) ☐ Pneumonia ☐ Pre-admission/pre-injury/pre-operative leg swelling/ulcers/varicose veins ☐ Recent confining travel (air or ground) greater than 4 hrs **Hypercoagulability** ☐ Documented history of DVT or PE **(3 points)** ☐ Estrogenic hormone use (estrogen, tamoxifen, etc.) ☐ Family history of DVT or PE ☐ Hypercoagulable states (lupus anticoagulant, etc.) **(3 points)** ☐ Indwelling central venous catheter ☐ Inflammatory bowel disease ☐ Myeloproliferative disorder (non-hemorrhagic) ☐ Nephrotic syndrome ☐ Pregnant, or postpartum less than 1 month ☐ Severe systemic infection or sepsis ☐ Systemic vasculitis ☐ Visceral malignancy

DVT Prophylaxis	
3 points or greater	SCD
2 points or less	No pharmacologic or mechanical DVT prophylaxis required

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Suspected Appendicitis Admission Orders (Medication Reconciliation)

Medication Reconciliation: List all patient's home medications (include samples, OTC, vitamins, herbals, and others); Select Continue or Discontinue for this admission. **Do not duplicate orders written here in the next medication order sections.** (Prohibited abbreviations: qd, qod, U, IU, lack of leading zero .X, trailing zero X.0, MS, MSO4, MgSO4)

Information source: ______________________ ☐ Patient not currently taking medication ☐ Medication history not available

Weight: _______kg ________ lbs ☐ Measured ☐ Stated Height: _______ cm ______ ft ___ in ☐ Pregnant ☐ Breastfeeding

FOR THIS ADMISSION	CURRENT HOME MEDICATIONS	DOSE	ROUTE	FREQ
☐ Continue ☐ Discontinue				
	Instructions/indications			
☐ Continue ☐ Discontinue				
	Instructions/indications			
☐ Continue ☐ Discontinue				
	Instructions/indications			
☐ Continue ☐ Discontinue				
	Instructions/indications			
☐ Continue ☐ Discontinue				
	Instructions/indications			
☐ Continue ☐ Discontinue				
	Instructions/indications			
☐ Continue ☐ Discontinue				
	Instructions/indications			
☐ Continue ☐ Discontinue				
	Instructions/indications			
☐ Continue ☐ Discontinue				
	Instructions/indications			

Additional Meds/Orders:	DOSE	ROUTE	FREQ

Other:

Provider Signature: ______________________ ID#: __________

Date: ______________________ Time: __________ AM / PM

RN Signature: ______________________ Initials: __________

Date: ______________________ Time: __________ AM / PM

Clerk/LVN Signature: ______________________ Initials: __________

Date: ______________________ Time: __________ AM / PM

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