



PHYSICIAN'S PREPRINTED ORDERS

TITLE:	ACUTE EXACERBATION COPD ADMISSION ORDERS
PHYSICIAN/GROUP:	EIRMC HOSPITALIST SERVICE

1. **Other Diagnosis** _____

2. Place in EIRMC Hospitalist Program
 Admit as an inpatient to _____ Telemetry

3. **Allergies:**
 NKDA Other _____

4. **Code Status** Full Do Not Resuscitate

5. **Vital Signs:** Q 2 hr Q 4 hr Q shift
 Other _____

6. **Activity:** Up ad lib BRP Pulm Rehab Consult
 Other _____

7. **Diet:**
 Regular NPO
 ADA _____ cal diet NPO except meds
 AHA diet Consult Nutrition

8. O₂ @ _____ L/min Titrate from _____ to _____
 Pulse Oximeter ABG

9. Smoking Cessation counseling if indicated

10. **Vaccines:** Pneumovax IM and seasonal Flu vaccine, if indicated

11. **DVT Prophylaxis**
 Lovenox _____ mg SubQ every _____ hr
 Arixtra _____ mg SubQ every _____ hr
 Heparin 5000 units SubQ every 8 hr
 SCDs bilaterally

 Contraindication: _____

12. **IV:** Saline Lock IV Electrolyte Protocol
 IV _____ @ _____/h

13. **Respiratory**
 SoluMedrol _____ mg IV q _____
 Prednisone _____ mg PO q _____
 Duoneb inh q _____ hr
 Albuterol 0.083% nebs inh q _____ hr prn SOB
 Spiriva 18 mcg inh daily
 Advair _____ 1 puff inh BID
 Formoterol 20 mcg/2ml neb inh BID
 Acapella Incentive spirometry

14. **Antibiotics**
 Ceftriaxone 1 gm IV q 24 hr and Azithromycin 500 mg IV q 24 hr **or**
 Doxycycline 100 mg IV Q12 hr
 Levofloxacin _____ mg IV q _____ hr **or**
 Other _____

15. **Other Medications:**
 Zofran 4 mg IV or PO q 4 hr severe nausea
 Colace 100 mg PO BID with 8 ounces of water
 Metamucil 1 packet with water daily BID prn
 Dulcolax 10 mg PR now daily prn
 Other _____

Nicotine patch _____ mg q 24 hr
 Tylenol 650 mg q 4 hr PO or PR prn mild pain or temp > 101.5
 Morphine _____ mg IV q _____ hr prn severe pain
 Fentanyl _____ mcg IV q _____ hr prn severe pain
 Hydrocodone/APAP _____ mg q _____ hr prn moderate pain
 PCA (see order sheet)

 Consult Pain Management Service

16. **In AM:** CXR, PA and Lat CXR, Portable

17. **Labs, in AM:**
 CBC & diff Procalcitonin
 Chem 13 Chem 7
 UA, C/S if indicated ABG
 _____ _____

18. **Now:**
 Blood cultures X 2; if not already completed
 Sputum sample - gram stain, C&S, if not already

Signature _____

Date _____ Time _____



Patient Identification