

Femur Fracture Spica Cast

Computerized Provider Order Entry (CPOE)

Admission Order set*

October, 2005

These are screenshots to be used as a guide for transcribing orders onto a written order sheet when ICIS is down. Do not fax this screen shot document to pharmacy or other receiving department.

[*See Explanation of Front & Back Page Orders in separate document](#)

***** FEMORAL FX ADMIT-SPICA CAST *****	
<input type="checkbox"/>	ADMIT TO
<input type="checkbox"/>	ISOLATION
<input type="checkbox"/>	INITIATE FEMORAL FRACTURE EBCP GUIDELINE
<input type="checkbox"/>	C-SPINE STATUS: (INDICATE CHOICE)
*** RADIOLOGY ***	
<input checked="" type="checkbox"/>	FEMUR - 2 VIEWS AP, LATERAL (IF NOT DONE PREVIOUSLY)
*** VITAL SIGNS ***	
<input type="checkbox"/>	VITAL SIGNS (TPR W/ BP) Q4H
<input type="checkbox"/>	NEURO/VAS CHECKS Q1H X 4, THEN Q4H (ENTER BODY SITE)
<input type="checkbox"/>	I AND O (STRICT) Q4H
<input type="checkbox"/>	PAIN SCORE PER CHMC POLICY Q4H
<input type="checkbox"/>	PAIN SCORE PER CHMC POLICY PRN
*** ACTIVITY ***	
<input type="checkbox"/>	TURN SIDE/SIDE AND SUPINE/PRONE Q4H
<input checked="" type="checkbox"/>	ORTHO ACTIVITY (FOR PATIENT WITH SPICA CAST)
<input checked="" type="checkbox"/>	MAY GO TO ACTIVITY CENTER PRN
*** NURSING ***	
<input checked="" type="checkbox"/>	ELEVATE EXTREMITY (LEFT LEG)
<input checked="" type="checkbox"/>	ELEVATE EXTREMITY (RIGHT LEG)
<input type="checkbox"/>	ICE TO EXTREMITY FEMUR (IDENTIFY LOCATION)

<input type="checkbox"/>	ICE TO EXTREMITY FEMUR (IDENTIFY LOCATION)
<input checked="" type="checkbox"/>	CAST CARE INSTRUCTIONS:
<input checked="" type="checkbox"/>	PETAL CAST EDGES WITH MOLESKIN
<input type="checkbox"/>	ARRANGE HOME MEDICAL EQUIPMENT (SELECT ITEMS NEEDED)
	*** DIET ***
<input checked="" type="checkbox"/>	CLEAR LIQUID ADV AS TOLERATED
	*** IVF ***
<input type="checkbox"/>	START IV TO SW STAT (IF NOT DONE PREVIOUSLY)
<input type="checkbox"/>	SODIUM CHLORIDE 0.9% FLUSH IV 0.5 - 3 ML Q8H
<input type="checkbox"/>	SELECT MAINTENANCE IV SOLUTION
	*** PAIN MANAGEMENT MEDICATION ***
<input checked="" type="checkbox"/>	KETOROLAC IV Q6H PRN FOR PAIN
	*** *** *** ***
<input checked="" type="checkbox"/>	MORPHINE IVP Q2H PRN FOR PAIN
	*** *** *** ***
<input checked="" type="checkbox"/>	IBUPROFEN SUSP PO Q6H
	*** *** *** ***
<input checked="" type="checkbox"/>	ACETAMINOPHEN ELIXIR PO PRN (FOR FEVER > 38.5 C OR PAIN)
<input checked="" type="checkbox"/>	ACETAMINOPHEN SUPP PR PRN (FOR FEVER > 38.5 C OR PAIN)
	*** *** *** ***
<input checked="" type="checkbox"/>	ACETAMINOPHEN/CODEINE ELIXIR PO PRN (FOR PAIN)

<input checked="" type="checkbox"/>	ACETAMINOPHEN ELIXIR PO PRN (FOR FEVER > 38.5 C OR PAIN)
<input checked="" type="checkbox"/>	ACETAMINOPHEN SUPP PR PRN (FOR FEVER > 38.5 C OR PAIN)
	*** *** *** ***
<input checked="" type="checkbox"/>	ACETAMINOPHEN/CODEINE ELIXIR PO PRN (FOR PAIN)
	*** OTHER MEDICATIONS ***
<input type="checkbox"/>	DIAZEPAM IVP PRN FOR MUSCLE SPASMS
	*** NOTIFY IF ***
<input type="checkbox"/>	NOTIFY IF: TEMP > 38.5 C OR HR > (ENTER PARAMETERS)
<input type="checkbox"/>	NOTIFY ATTENDING OR HO WHEN DISCHARGE GOALS MET
	*** EDUCATE ***
<input type="checkbox"/>	INITIATE TEACHING ABOUT SPICA CAST PER FEMUR FX EDUC RECORD
<input type="checkbox"/>	UTILIZE FEMORAL FRACTURE DISCHARGE INSTRUCTION SHEET
	*** CONSULTS ***
	*** IF ABUSE SUSPECTED, ORDER SOCIAL SERVICES CONSULT **
<input checked="" type="checkbox"/>	SOCIAL SERVICES CONSULT

INITIATE - STAT * Required

Once q CONT Until D/C
 WK/MO FREQUENCIES For

*Priority: ROUTINE *Start Dt/Tm: 9/21/2005 at 1436

Addl. Information Regarding Order

FEMORAL FRACTURE EVIDENCE
BASED CLINICAL PRACTICE
GUIDELINE.

OK Cancel Order Help

New Order **COE Feedback**

C-SPINE STATUS: * Required

Once
 q
 Until D/C
 WK/MO FREQUENCIES
 For

*Priority: *Start Dt/Tm: at

Addl. Information Regarding Order

PLACE AN "X" APPROPRIATELY:

SEE ED NOTE

SEE TRAUMA NOTE

OTHER:

New Order : Radiology **COE Feedback**

FEMUR - 2 VIEWS **STAT**

*Priority: **STAT** Sched Exam On: in

*View: **AP, LATERAL**

*Portable?
 NO
 YES

*L/R/Bilat
 Left
 Right
 Bilateral

*Indications:
POST SPICA CAST

Addl. Info./Questions to be Answered:

*Contact MD:
 Pager: **1**
 Phone:
 Fax Report To:
 Call Regardless of Results

Messages * Required

Additional Results To:
 MD Name:
 Pager/Phone:

*Clinical Information: (Limit Abbreviations)

VITALS (TPR W/ BP)

* Required

*Priority: ROUTINE

*How often?

q Q4H Until D/C
 For [] [] , then

q [] Until D/C
 For [] [] , then

q [] Until D/C
 For [] []

Addl. Information Regarding Order

TEMPERATURE IVAC ORAL OR
RECTAL ONLY

OK Cancel Help

NEURO/VAS CHECKS

* Required

*Priority:

*How often?

<input type="checkbox"/> q	<input type="text" value="Q1H"/>	<input type="radio"/> Until D/C
		<input checked="" type="radio"/> For <input type="text" value="4"/> <input type="text" value="TIMES"/>
, then		
<input checked="" type="checkbox"/> q	<input type="text" value="Q4H"/>	<input checked="" type="radio"/> Until D/C
		<input type="radio"/> For <input type="text"/> <input type="text"/>
, then		
<input type="checkbox"/> q	<input type="text"/>	<input type="radio"/> Until D/C
		<input type="radio"/> For <input type="text"/> <input type="text"/>

Body Site: Right
 Left
 Bilateral

Addl. Information Regarding Order

ENTER BODY SITE
Q1H X 4 ON ARRIVAL, THEN Q4H

I&O

STAT

* Required

Once q Until D/C
 WK/MO FREQUENCIES For

*Priority: *Start Dt/Tm: at

Intake and Output Specifics

Strict
 W/Diaper Wts

Addl. Information Regarding Order

OK Cancel Order Help

PAIN SCORE

* Required

Once q **Q4H** Until D/C
 WK/MO FREQUENCIES For

*Priority: **ROUTINE** *Start Dt/Tm: **9/21/2005** at **1436**

- Per CHMC Policy
- Or
- Choose Specific Pain Scale

Addl. Information Regarding Order

EVALUATE NEED FOR
ROUND-THE-CLOCK PAIN
MEDICATION FREQUENTLY

New Order **COE Feedback**

PAIN SCORE STAT * Required

Once q **PRN** Until D/C
 WK/MO FREQUENCIES For

*Priority: **ROUTINE** *Start Dt/Tm: **9/21/2005** at **1436**

Per CHMC Policy
Or
 Choose Specific Pain Scale

— Addl. Information Regarding Order —
EVALUATE NEED FOR
ROUND-THE-CLOCK PAIN
MEDICATION FREQUENTLY

New Order **COE Feedback**

TURN **STAT** * Required

Once q **Q4H** Until D/C
 WK/MO FREQUENCIES For

*Priority: **ROUTINE** *Start Dt/Tm: **9/21/2005** at **1436**

Turning Specifications
SIDE/SIDE AND SUPINE/PRONE

Addl. Information Regarding Order

ORTHO ACTIVITY

* Required

*Start Dt/Tm: 9/21/2005 at 1436

Until D/C or For

then _____

then _____

then _____

then _____

Positioning

Mode of Transportation

Turning

Wt Bearing Status

Addl. Information Regarding Order

OK Cancel Help

MAY GO TO ACTIVITY CENTER

STAT

* Required

Once q Until D/C
 WK/MO FREQUENCIES For

*Priority: *Start Dt/Tm: at

Addl. Information Regarding Order

OK Cancel Order Help

ELEVATE EXTREMITY

STAT

* Required

Once

q

CONT

Until D/C

WK/MO FREQUENCIES

For

*Priority: ROUTINE

*Start Dt/Tm: 9/21/2005

at 1436

Additional Order Specifics

Left

Body Site:

Right

LEG

Use Pillows

W/ Sling

Hang W/ Stockinette

Addl. Information Regarding Order

Empty text area for additional information regarding the order.

OK

Cancel Order

Help

ELEVATE EXTREMITY

STAT

* Required

Once q Until D/C
 WK/MO FREQUENCIES For

*Priority: *Start Dt/Tm: at

Additional Order Specifics

Left Right Body Site:
 Use Pillows
 W/ Sling
 Hang W/ Stockinette

Addl. Information Regarding Order

OK Cancel Order Help

ICE TO EXTREMITY

STAT

* Required

Once q **CONT** Until D/C
 WK/MO FREQUENCIES For [] []

*Priority: **ROUTINE** *Start Dt/Tm: **9/21/2005** at **1436**

Body Site:
 Left Right Bilat
FEMUR

Addl. Information Regarding Order

[Empty text area with scroll bars]

OK Cancel Order Help

New Order

COE Feedback

CAST CARE INSTRUCTIONS:

STAT

* Required

Once

q

CONT

Until D/C

WK/MO FREQUENCIES

For

*Priority: ROUTINE

*Start Dt/Tm: 9/21/2005 at 1436

Addl. Information Regarding Order

- _KEEP CAST DRY
- _ASSESS SKIN AROUND CAST Q4H
- _PETAL CAST EDGE WITH MOLESKIN
- _SELECT DIAPER TO FIT CAST PERINEAL OPENING. LINE DIAPER WITH POISE PAD THEN TUCK DIAPER UNDER CAST EDGES AROUND PERINEAL OPENING
- _TEACH PARENT DIAPERING PROCEDURE

OK

Cancel Order

Help

PETAL CAST EDGES

STAT

* Required

Once q Until D/C
 WK/MO FREQUENCIES For

*Priority: *Start Dt/Tm: at

Addl. Information Regarding Order

WITH MOLESKIN

OK

Cancel Order

Help

New Order

COE Feedback

ARRANGE HOME MEDICAL EQUIPMENT

STAT

* Required

Once

q

CONT

Until D/C

WK/MO FREQUENCIES

For

*Priority: ROUTINE

*Start Dt/Tm: 9/21/2005 at 1436

Addl. Information Regarding Order

(PLACE "X" NEXT TO SELECTIONS)

_ WHEELCHAIR W/ LEG LIFTS

_ RECLINING WHEELCHAIR

_ SNUG SEAT

(DOCTOR PLACE RX ON CHART)

OK

Cancel Order

Help

New Order COE Feedback ?

CLEAR LIQUID ADV AS TOLERATED * Required

q CONT Until D/C

*Start Dt/Tm: 9/21/2005 at 1436

Additional Directions:

START IV TO SW

STAT

* Required


Once q Until D/C
 WK/MO FREQUENCIES For

*Priority: STAT *Start Dt/Tm: 9/21/2005 at 1436

Addl. Information Regarding Order

INSERT 2 LARGE BORE PIVS FOR TRAUMA PATIENTS OR 1 LARGE BORE PIV FOR NON-TRAUMA PATIENTS IF NOT ALREADY DONE

OK Cancel Order Help

New Order Policy  Calculator COE Feedback

0.9% NL SALINE FLUSH/BARRIER * Required

Type of Flush: Intermittent Dosing Wt: 34. KG

* Must Select a Type of Catheter:

TUNNELED, NON-TUNNELED
 TUNNELED, NON-TUNNELED RCNIC
 MEDIPORT, UNACCESSED
 MEDIPORT, ACCESSED
 PHERESIS/DIALYSIS
 PICC 2 FR
 PICC 3 FR
 PICC 4 FR
 UMBILICAL CVC
SALINE WELL
 PICC INSERTION

Volume Per Lumen: 0.5 - 3 ML


*Clinician Contact
 Pager: 1

q Q8H STAT Until D/C
 For

*Priority: ROUTINE

*Start Dt/Tm: 9/21/2005 at 1436

Additional Directions:

OK Cancel Order Formulary  Help

Dosing Wt: 34. KG

- Select
- Maintenance Solution:**
- Sodium Chloride 0.9%
 - Sodium Chloride 0.45%
 - Sodium Chloride 0.225%
 - Sodium Chloride 0.675%
 - Lactated Ringers

 - Dextrose 5%
 - Dextrose 5%-NS
 - Dextrose 5%-LR
 - Dextrose 5%-1/2 NS
 - Dextrose 5%-1/4 NS
 - Dextrose 5%-3/4 NS
 - Intralipids 20%
(Fat Emulsion)
 - TPN
 - Intralipids (With TPN)

RX to Send IV Fluid to:
 OR PACU Floor

Clinician Contact Pager:
1

Additional Directions:

OK Cancel Order Help

KETOROLAC 15MG/ML VIAL

Dose Calculator

Brand Name Equivalent: TORADOL

*Dose: MG*Dosing Wt: KG*Route: Once q Until D/C WK/MO FREQUENCIES For * Clinician Contact
Pager:*Priority: *Start Dt/Tm: at

If PRN, Reason:

 Meds Already Given Do Not Administer Unless Directed

Additional Directions:

OK

Cancel Order

Formulary 

Help

New Order

Calculator COE Feedback

KETOROLAC 15MG/ML VIAL

DOSE CALCULATOR FOR: KETOROLAC 15MG/ML VIAL

Brand Name Equivalent: TORADOL

Dosing Wt Ideal Body Wt (IBW) Height

34. KG 7.187 KG 66.00 CM

$IBW = (HT \times HT) \times 1.65 / 1000$

$BSA = \text{SQRT}((DOSE\ WT \times HT) / 3600)$

*Dose: MG

*Route: INTRAVENOUS

Once q Q6H 1st STAT

0.7894 M2 Recalculate BSA

STATx1 Non-Std WK/MO FREQUENCIES

*Priority: PRN *Start Dt/Tm: 9/21/2005

If PRN, Reason:

PAIN

Meds All Do Not

Formula	Value	Unit(s)
<input checked="" type="checkbox"/> KG	0.5	MG/KG
<input type="checkbox"/> BSA		
<input type="checkbox"/> Rate		

% Reduction

Calculate Dose

OK

Keep Calculated Values

Close

New Order HighAlert Policy Calculator COE Feedback

MORPHINE Dose Calculator

Brand Name Equivalent: MORPHINE SULFATE

*Dose: MG *Dosing Wt: KG

*Route:

Once
 q
 Until D/C

 WK/MO FREQUENCIES
 For

*Clinician Contact Pager:

*Priority: *Start Dt/Tm: at

If PRN, Reason:

 Meds Already Given

 Do Not Administer Unless Directed

Additional Directions:

6 MONTHS OR YOUNGER:
0.05 MG/KG/DOSE IVP Q2H PRN
GREATER THAN 6 MONTHS:
0.1 MG/KG/DOSE IVP Q2H PRN
MAX DOSE 5 MG IV

New Order

Calculator COE Feedback

IBUPROFEN 100MG/5ML ORALSUSP

* Required Dose Calculator

Brand Name Equivalent: MOTRIN

*Dose: MG Dosage Form: ORAL SUSP Dosing WT: KG

*Route: ORAL

Once q Q6H 1st STAT Until D/C
STATx1 Non-Std WK/MO FREQUENCIES For

*Clinician Contact Pager:

*Priority: ROUTINE *Start Dt/Tm: 9/21/2005 at 1436

If PRN, Reason:

- Do Not Administer Unless Directed
- Meds Already Given

Recommended Dosing Range
Route: PO
Per Dose Min: 4 MG/KG Daily Frequency: Min: 1
Per Dose Max: 10 MG/KG Max: 4
Daily Dose Not to Exceed: 40 MG/KG

Additional Directions:
5 MG/KG/DOSE OR 10 MG/KG/DOSE
(MAX DOSE = 400 MG)

OK Cancel Order Formulary Help

New Order

Calculator

COE Feedback

ACETAMINOPHEN 160 MG/5 ML ELIXIR

* Required

Dose Calculator

Brand Name Equivalent: TYLENOL

*Dose: MG

Dosage Form: ELIXIR

Dosing WT: KG

*Route:

Once

q

1st STAT

Until D/C

STATx1

Non-Std

WK/MO FREQUENCIES

For

*Clinician Contact Payer:

*Priority:

*Start Dt/Tm: at

If PRN, Reason:

Do Not Administer Unless Directed

Meds Already Given

Recommended Dosing Range

Route: PO

Per Dose Min: 10 MG/KG

Per Dose Max: 15 MG/KG

Daily Dose Not to Exceed: 90 MG/KG

Daily Frequency:

Min: 1

Max: 6

MG/KG

Additional Directions:

10-15 MG/KG/DOSE
(MAX OF 5 DOSES/DAY)

OK

Cancel Order

Formulary



Help

New Order Calculator **COE Feedback**

ACETAMINOPHEN 120MG SUPP * Required Dose Calculator

Brand Name Equivalent: TYLENOL

*Dose: MG Dosage Form: SUPP Dosing WT: KG

*Route: PER RECTUM

Once
 q 1st STAT
 Until D/C

STATx1
Non-Std
 W/K/MO FREQUENCIES
 For

*Priority: PRN *Start Dt/Tm: 9/21/2005 at 1436

If PRN, Reason:

FOR FEVER > 38.5 C

PAIN

Do Not Administer Unless Directed
 Meds Already Given

Additional Directions:

10-15 MG/KG/DOSE
(MAX OF 5 DOSES/DAY)

OK
Cancel Order
Formulary
Help

New Order

Calculator **COE Feedback**

ACETAMINOPHEN/CODEINE ELIXIR 12MG/5ML

* Required **Dose Calculator**

Brand Name Equivalent: TYLENOL/CODEINE ELIXIR

*Dose: [] [] Dosage Form: ELIXIR Dosing WT: 34. KG
*Route: ORAL

Once q [] 1st STAT Until D/C
STATx1 Non-Std WK/MO FREQUENCIES For [] []
*Clinician Contact Pager: 1

*Priority: PRN *Start Dt/Tm: 9/21/2005 at 1436

If PRN, Reason:
PAIN
[]

Do Not Administer Unless Directed
 Meds Already Given

Recommended Dosing Range
Route: PO Daily Frequency:
Per Dose Min: 0.5 MG/KG Min: 1
Per Dose Max: 1 MG/KG Max: 6
Daily Dose Not to Exceed: 360 MG

Additional Directions:
1 MG CODEINE/KG/DOSE
(MAX 60 MG CODEINE/DOSE)
(MAX 5 DOSES/DAY)

OK Cancel Order Formulary **i** Help

New Order HighAlert Policy Calculator COE Feedback

DIAZEPAM Dose Calculator

Brand Name Equivalent: VALIUM

*Dose: MG *Dosing Wt: KG

*Route:

Once
 q
 Until D/C

 WK/MO FREQUENCIES
 For

*Clinician Contact Payer:

*Priority: *Start Dt/Tm: at

If PRN, Reason:

 Meds Already Given

 Do Not Administer Unless Directed

Additional Directions:

New Order HighAlert Policy Calculator COE Feedback

DIAZEPAM **DOSE CALCULATOR FOR: DIAZEPAM**

Brand Name Equivalent: VALIUM

Dosing Wt 34. KG Ideal Body Wt (IBW) 7.187 KG Height CM

*Dose: MG $IBW=(HT \times HT) \times 1.65 / 1000$

*Route: IV PUSH $BSA=SQRT((DOSE\ WT \times HT)/3600)$

Once q M2 **Recalculate BSA**

WK/MO FREQUENCIES

*Priority: PRN *Start Dt/Tm: 9/21/2005

If PRN, Reason:

MUSCLE SPASMS Meds All Do Not

% Reduction Keep Calculated Values

NOTIFY IF STAT

* Required

Once q Until D/C
 WK/MO FREQUENCIES For

*Priority: *Start Dt/Tm: at

Vital Sign Parameters/Others To Be Notified Of:

- Temperature < Or > Centigrade
- Pulse < Or > bpm
- Respirations _____
- Systolic Blood Pressure _____
- Diastolic Blood Pressure _____
- Oxygen Saturation _____
- Urine Output _____
- Other _____
- Other _____

Add. Information Regarding Order

OK Cancel Order Help

NOTIFY

STAT

* Required

Once

q CONT

Until D/C

WK/MO FREQUENCIES

For

*Priority: ROUTINE

*Start Dt/Tm: 9/21/2005 at 1436

Select From Drop Down or Type In

ATTENDING OR HO

IF WHEN DISHCARGE GOALS ARE MET

(150 Characters of Text)

*Clinician Contact:

Pager:

1

Phone:

Addl. Information Regarding Order

OK

Cancel Order

Help

New Order

COE Feedback

UTILIZE

STAT

* Required

Once

q CONT

Until D/C

WK/MO FREQUENCIES

For

*Priority: ROUTINE

*Start Dt/Tm: 9/21/2005 at 1436

Add. Information Regarding Order

FEMORAL FRACTURE DISCHARGE
INSTRUCTION SHEET

OK

Cancel Order

Help

BEGIN EDUCATION ABOUT


STAT

* Required

Once q Until D/C
 For

*Priority: *Start Dt/Tm: at

*About:

 Clinical Effectiveness Link

— Addl. Information Regarding Order —
DISCHARGE TEACHING AS PER
FEMORAL FRACTURE EDUCATION
RECORD

OK Cancel Order Help

SOCIAL SERVICES CONSULT REQ

Stat

* Required

*Priority: **ROUTINE**

*Requesting Service:

*Service:

BLUE TEAM

Pager:

1

Phone:

Fax Report To:

Fax Needed:

Attending Name:

ABLER, CHARLES V

**Call or Page Consulting Department
in Addition to Placing this Order.**

On-Call Contact:

MD Name:

Pager/Phone:

*Indications:

CHILD ABUSE EVALUATION

Add. Info./Questions to be answered:

CALL SOC SERV AT 636-4711 OR
PAGE 736-4410 (24 HRS A DAY).

*Clinical Information:

OK

Cancel

Help