

# Gastroenteritis (Acute)

Computerized Provider Order Entry (CPOE)

Admission Order set\*

December, 2006

**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](#)

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\*\*\*\*\* GASTROENTERITIS (ACUTE)\*\* \*\*\*\*\*

ADMIT TO

ISOLATION

UTILIZE GASTROENTERITIS EBCP GUIDELINE & IPOC

\*\*\* DIET \*\*\*

PROGRESSIVE DIET

NUTRITION: OFFER PEDIALYTE (10 ML/KG) FOR EA. STOOL/EMESIS

\*\*\* VITALS SIGNS \*\*\*

AUTOMATIC BLOOD PRESSURE DAILY

VITALS (TPR) Q4H

VITALS (TPR W/ BP) Q4H

\*\*\* NOTIFY IF \*\*\*

NOTIFY IF (VITAL SIGNS PARAMETERS)

NOTIFY H.O. (FREE TEXT INSTRUCTIONS)

\*\*\* NURSING \*\*\*

HEIGHT ON ADMISSION

WEIGHT DAILY

ASSESS PERFUSION/HYDRATION Q4HR

I AND O (STRICT) QSHIFT

*** ACTIVITY ***	
<input type="checkbox"/>	UP AD LIB
*** IVF HYDRATION ***	
<input checked="" type="checkbox"/>	START IV TO SALINE WELL
<input checked="" type="checkbox"/>	BOLUS: SODIUM CHLORIDE 0.9% ML OVER 1 HR
<input checked="" type="checkbox"/>	SELECT MAINTENANCE SOLUTION
<input checked="" type="checkbox"/>	CHANGE IV TO SALINE WELL WHEN TAKING ADEQUATE PO
*** ORDER FLUSH IF IV FLUID OR SALINE WELL ORDERED ***	
<input checked="" type="checkbox"/>	SODIUM CHLORIDE 0.9% FLUSH IV 0.5 - 3 ML QPRN
*** MEDICATIONS ***	
<input checked="" type="checkbox"/>	ACETAMINOPHEN PO Q4H PRN (100 MG/ML DROPS)
<input checked="" type="checkbox"/>	ACETAMINOPHEN PO Q4H PRN (160 MG/ 5 ML ELIXIR)
<input checked="" type="checkbox"/>	ACETAMINOPHEN PR Q4H PRN (80 MG SUPP)
*** EDUCATION ***	
<input type="checkbox"/>	BEGIN GASTROENTERITIS EDUC PER GASTROENTERITIS EDUC RECORD
*** NOTIFY ***	
<input type="checkbox"/>	DISCHARGE PATIENT WHEN D/C GOALS MET & NOTIFY MD

**ADMIT TO**

\* Required

Is the Patient Going to be in the Hospital more than 24 hours?

Yes  No

Nurse Station:

\*Name of Resident Team Covering:

Private Physician:

TIAO, GREGORY M., M.D.

\*Attending Dr Name:

\*Dosing Weight:

gm

kg  Kg

Height:

cm

\*Hospital Service:

\*Pt Condition:

Current Diagnosis:

Current Diagnosis #2:

Intern Name:

Intern Pager #:



\*Isolation: Questions? Call X6-8492

Standard Precautions

Enter Other Isolation

OK

Cancel Order

Help

ISOLATION



List of Isolation Policy Links

\* Required

Types of Isolation

- Airborne
- Contact
- Droplet
- N95 Airborne

- Protective
- Respiratory Contact
- Strict
- Strict Protective

Addl. Information Regarding Order

OK

Cancel

Help

UTILIZE EBCP GUIDELINE & IPOC

STAT

\* Required

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

\*Priority: **ROUTINE**    \*Start Dt/Tm: **12/4/2006** at **1725**

Addl. Information Regarding Order

UTILIZE GASTROENTERITIS  
EVIDENCE BASED CLINICAL  
PRACTICE GUIDELINE & IPOC.

OK

Cancel Order

Help

**PROGRESSIVE/TEMPORARY DIET**

\* Required

\*Start Dt/Tm: 12/4/2006 at 1725

 PEDIALYTE IN FREQUENT FEEDS Until D/C or  For Until W/O EMESIS FOR 2 HOURS Add Diet Restrict/Oral Supplements Add Enteral Feeding Information then REGULAR FOR AGE Until D/C or  For Until Add Diet Restrict/Oral Supplements Add Enteral Feeding Information then then

OK

Cancel

Help

Advancing Diet Level 1:

**PEDIALYTE IN FREQUENT FEEDS P**

\* Required

Advancing Diet Level 1 Duration:

**UNTIL W/O EMESIS FOR 2 HOURS**

\*Route:

Oral Product:

 Full Strength Other Strength

Feeding Schedule:

If ad lib feedings, estimated  
total intake per 24 hours = cc

Calories:

Fluid Restriction:

Protein:

Fat:

Sodium:

Potassium:

Other:

 Add Additional Directions/Comments

OK

Cancel Order

Help

Advancing Diet Level 2:

**REGULAR FOR AGE**

\* Required

Advancing Diet Level 2 Duration:

**UNTIL D/C**

\*Route:

Oral Product:

- Full Strength  
 Other Strength

Feeding Schedule:

If ad lib feedings, estimated  
total intake per 24 hours = cc

Calories:

Fluid Restriction:

Protein:

Fat:

Sodium:

Potassium:

Other:

 Add Additional Directions/Comments

OK

Cancel Order

Help

NUTRITION: OFFER PEDIALYTE STAT

\* Required

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

\*Priority: ROUTINE    \*Start Dt/Tm: 12/4/2006 at 1725

Addl. Information Regarding Order

OFFER 10 ML/KG OF PEDIALYTE  
CLEAR LIQUID SUPPLEMENT FOR  
EACH STOOL/ EMESIS.

OK    Cancel Order    Help

**AUTOMATIC BLOOD PRESSURE**

\* Required

\*Priority: **ROUTINE**

\*How often?

<input type="checkbox"/> q	<b>DAILY</b>	<input checked="" type="radio"/> Until D/C	<input type="radio"/> For [ ] [ ] , then
<input type="checkbox"/> q	[ ]	<input type="radio"/> Until D/C	<input type="radio"/> For [ ] [ ] , then
<input type="checkbox"/> q	[ ]	<input type="radio"/> Until D/C	<input type="radio"/> For [ ] [ ] , then

Addl. Information Regarding Order

ON ADMISSION THEN DAILY

OK Cancel Help

VITALS (TPR)

\* Required

\*Priority: ROUTINE

\*How often?

<input 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"/>	, then
<input type="checkbox"/> q	<input type="text"/>	<input type="radio"/> Until D/C	<input type="radio"/> For <input type="text"/> <input type="text"/>	, then

Addl. Information Regarding Order

PERFUSION/HYDRATION  
ASSESSMENT WITH VITAL SIGNS

OK

Cancel

Help

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 [ ] [ ] , then

Addl. Information Regarding Order

PERFUSION/HYDRATION  
ASSESSMENT WITH VITAL SIGNS

OK

Cancel

Help

NOTIFY IF

STAT

\* Required

Once

q **CONT**

Until D/C


WK/MO FREQUENCIES

For

\*Priority: **ROUTINE**

\*Start Dt/Tm: **12/4/2006** at **1725**

Vital Sign Parameters/Others To Be Notified Of:

Normal Ranges 

Temperature <  Or >  Centigrade

Pulse

Respirations

Systolic Blood Pressure

Diastolic Blood Pressure

Oxygen Saturation

Urine Output

Other

Other

Addl. 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: **12/4/2006** at **1725**

**Select From Drop Down or Type In**

House Officer

IF

[Empty text area for IF condition]

(150 Characters of Text)

**\*Clinician Contact:**

**Pager:**

**1**

**Phone:**

[Empty field]

Addl. Information Regarding Order

[Empty text area for additional information]

OK

Cancel Order

Help

HEIGHT

STAT

\* Required

Once

q

Until D/C

WK/MO FREQUENCIES

For

\*Priority: ROUTINE

\*Start Dt/Tm: 12/4/2006 at 1725

Addl. Information Regarding Order

ON ADMISSION

OK

Cancel Order

Help

**WEIGHT**

\* Required

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

\*Priority: **ROUTINE** \*Start Dt/Tm: **12/4/2006** at **1725**

Weight Specifics

Nude  In Hospital Gown  
 Use Specific Scale (Identify)

---

Before Breakfast  In Afternoon

---

After Voiding  Blind Wt

Addl. Information Regarding Order

ON ADMISSION THEN DAILY

**ASSESS PERFUSION/HYDRATION**

STAT

\* Required

Once     q **Q4HR**     Until D/C  
 WK/MO FREQUENCIES     For [ ] [ ]

\*Priority: **ROUTINE**    \*Start Dt/Tm: **12/4/2006** at **1725**

Addl. Information Regarding Order  
WITH VITAL SIGNS

OK    Cancel Order    Help

I&amp;O

STAT

\* Required

 Once q

QSHIFT

 Until D/C WK/MO FREQUENCIES For

\*Priority: ROUTINE

\*Start Dt/Tm: 12/4/2006 at 1725

## Intake and Output Specifics

 Strict W/Diaper Wts

## Addl. Information Regarding Order

EXACT INTAKE WHEN ON IVF;  
ESTIMATE INTAKE IF NOT ON IVF;  
RECORD COUNTS AND ROUTES OF  
ALL FLUID LOSSES (OUTPUTS)

OK

Cancel Order

Help

UP AD LIB

STAT

\* Required

Once

q

CONT

Until D/C

WK/MO FREQUENCIES

For

\*Priority: ROUTINE

\*Start Dt/Tm: 12/4/2006

at 1725

Additional Order Specifics

May Go to Unit Activity Center

Encourage Active ROJM

Encourage Ambulation

Preferred Method of Transportation

Addl. Information Regarding Order

RESTRICTIONS PER ISOLATION

OK

Cancel Order

Help

START IV TO SALINE WELL

STAT

\* Required

Once

q

Until D/C

WK/MO FREQUENCIES

For

\*Priority: ROUTINE

\*Start Dt/Tm: 12/4/2006

at 1725

Addl. Information Regarding Order

OK

Cancel Order

Help

Dosing Wt: 22 KG

Select Bolus Solution:

Crystalloids and Volume Expanders:

- Sodium Chloride 0.9%
- Lactated Ringers
  
- Albumin 5%
- Albumin 25%
- Dextran 10%-D5W
- Dextran 10%-NS
- Hetastarch 6%-NS
- Plasma Protein 5%
- Plasma-Lyte A pH 7.4

Additional Bolus Solutions:

- Arginine 10%
- Dextrose 10%
- Dextrose 10%-NS
- Dextrose 25%

Bolus Information:

Bolus Volume: 1 ml  
Infuse Over: 1  Hr(s)  
 Min(s)  
Or:  IVPush

Bolus Indication:

HYPOVOLEMIA

Priority:  Stat  Routine  
STAT For Use With One Time Orders Only

Route:  Peripheral IV  
 Central Venous Catheter

Bolus Already Given

Administration Information:

SOLUTION SELECTED

SODIUM CHLORIDE 0.9%

Select For Additional Doses

Currently Set as a One Time Order

Order Starts On:

12/4/2006 at 1725

RX to Send IV Fluid to:

OR  PACU  Floor

Clinician Contact Pager:

1

Additional Directions:

Empty text area for additional directions.

OK

Cancel Order

Help

Dosing Wt: 22 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

CHANGE IV TO SALINE WELL

STAT

\* Required

Once

q CONT

Until D/C

WK/MO FREQUENCIES

For

\*Priority: ROUTINE

\*Start Dt/Tm: 12/4/2006 at 1725

Addl. Information Regarding Order

WHEN TAKING ADEQUATE PO

OK

Cancel Order

Help

New Order Policy Calculator COE Feedback

**0.9% NL SALINE FLUSH/BARRIER** \* Required

Type of Flush:  Intermittent Dosing Wt: 22 KG

**Type of Catheter**  
**SALINE WELL** Volume Per Lumen: 0.5 - 3 ML

\*Clinician Contact Pager: 1

q QPRN STAT  Until D/C  
 For    

\*Priority: PRN

\*Start Dt/Tm: 12/4/2006 at 1725

Additional Directions:

OK Cancel Order Formulary Help

**New Order** Calculator **COE Feedback**

**ACETAMINOPHEN 100MG/ML DROPS** \* Required **Dose Calculator**

Brand Name Equivalent: **TYLENOL**

\*Dose:   Dosage Form: **DROPS** Dosing WT:  **KG**

\*Route:

Once  q    Until D/C  
    For

\*Clinician Contact Pager:

\*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	Daily Frequency:	Min: 1
Per Dose Max:	15	MG/KG		Max: 6
Daily Dose Not to Exceed:	90	MG/KG		

Additional Directions:

New Order

Calculator

COE Feedback

ACETAMINOPHEN 160 MG/5 ML ELIXIR

\* Required

Dose Calculator

Brand Name Equivalent: TYLENOL

\*Dose: 1 MG

Dosage Form: ELIXIR

Dosing WT: 22 KG

\*Route: ORAL

Once  q Q4H 1st STAT  Until D/C  
STATx1 Non-Std WK/MO FREQUENCIES  For

\*Clinician Contact  
Pager:

1

\*Priority: PRN \*Start Dt/Tm: 12/4/2006 at 1725

If PRN, Reason:

FEVER OR

PAIN

Do Not Administer Unless Directed

Meds Already Given

Additional Directions:

Empty text area for additional directions.

Recommended Dosing Range

Route: PO

Per Dose Min: 10 MG/KG

Per Dose Max: 15 MG/KG

Daily Dose Not to Exceed: 90

Daily Frequency:

Min: 1

Max: 6

MG/KG

OK

Cancel Order

Formulary



Help

New Order

Calculator

COE Feedback

ACETAMINOPHEN 80MG SUPP

\* Required

Dose Calculator

Brand Name Equivalent: TYLENOL

\*Dose: 1 MG

Dosage Form: SUPP

Dosing WT: 22 KG

\*Route: PER RECTUM

Once  q Q4H  1st STAT  Until D/C  
 STATx1  Non-Std  WK/MO FREQUENCIES  For

\*Clinician Contact Pager:

1

\*Priority: PRN \*Start Dt/Tm: 12/4/2006 at 1725

If PRN, Reason:

FEVER OR

PAIN

- Do Not Administer Unless Directed
- Meds Already Given

Additional Directions:

Empty text area for additional directions.

OK

Cancel Order

Formulary

Help

BEGIN EDUCATION ABOUT

STAT

\* Required

Once

q **CONT**


Until D/C

For

\*Priority: **ROUTINE**

\*Start Dt/Tm: **12/4/2006** at **1725**

\*About: **GASTROENTERITIS**

 [Clinical Effectiveness Link](#)

Addl. Information Regarding Order

PER GASTROENTERITIS EDUCATION  
RECORD.

OK

Cancel Order

Help

DISCHARGE CRITERIA: STAT

\* Required

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

\*Priority: ROUTINE    \*Start Dt/Tm: 12/4/2006 at 1725

Addl. Information Regarding Order

DISCHARGE PATIENT WHEN IPOC  
"DISCHARGE WHEN" GOALS ARE  
MET AND NOTIFY MD OF  
PATIENT'S DEPARTURE.

OK    Cancel Order    Help

