Saint Vincent Hospital

at Worcester Medical Center

Gastrointestinal Bleeding Standard Admission Orders

Check all that apply. Only items checked will be ordered.
Fill in required information where indicated.

DATE	TIME	ORDERS	NURSE'S SIGNATURE	TIME NOTED
		ALLERGY:		
		NATURE OF REACTION:		
		1. Admit to: ______________________ MD service ☐ Inpatient Status ☐ Observation Status (requires decision within 24 hours to discharge or convert to inpatient status) ☐ Covered Medicine Team: ____________ ☐ Uncovered Medicine		
		2. DIAGNOSIS: Gastrointestinal Bleeding		
		Secondary Diagnoses:		
		3. CODE STATUS: ☐ Full Code ☐ DNR/DNI — form completed		
		4. VITAL SIGNS: ☐ Full vital signs every ________ ☐ BP and P every ________ h; call if patient unstable. ☐ Assess orthostatics every __________		
		5. ACTIVITY: ☐ Bedrest with assist as appropriate ☐ Other: ______________________		
		6. NURSING: ☐ Record I & O (including stool, NGT, if applicable) ☐ NG tube ☐ Gravity ☐ Suction at ______________ ☐ Elevate head of bed _______ degrees ☐ Transfusions: ________ units PRBCs ________ units FFP ________ platelets		
		7. DIET: ☐ NPO ☐ Ice chips ☐ Other: ______________		
		8. ☐ IV: ____________ at ____________ cc/hour ☐ Peripheral IV lock — flush per protocol		
		9. DVT prophylaxis: ☐ Use only Venodynes until GI bleeding resolved		

______________________________ Practitioner

______________________________ R.N. Time & Date: ____________________

Do not write on the reverse side of this document.

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		10. MEDICATIONS: ☐ Medication History Form reviewed and reconciled ☐ Acid suppression ☐ Pantoprazole (Protonix) 40mg IV every 12 hours (requires GI approval after 24 hours) ☐ Pantoprazole (Protonix) 40mg p.o. now and every 12 hours ☐ Pantoprazole (Protonix) 40mg every 12 hours via feeding tube **or** ☐ Famotidine 20mg IV every 12 hours		
		Other medications:		
		11. LABS *(MD to place an "X" by tests needed)* ☐ CBC ☐ Basic Metabolic Panel ☐ Hepatic Function Panel ☐ PT/INR ☐ aPTT ☐ Urinalysis ☐ ABO ☐ Rh ☐ Antibody Screen (if not done in E.D.) ☐ Hgb ☐ Hct (every 6 hours for 24 hours). Notify MD if drop in HCT is equal or more than 4 points.		
		12. SPECIAL TESTS / RADIOLOGY: ☐ EKG (if not done in E.D.) — Indication (no rule out): ________________ ☐ CXR (if not done in E.D.) — Indication (no rule out): ________________		
		13. CONSULTS *(indicate name of consultant and reason)* / SPECIAL ORDERS: ☐ Gastroenterology: ____ ☐ Surgery: ____ ☐ Other consults: ____		
		14. VACCINES *(see Intranet for indications/contraindications)*: ☐ Administer ☐ Do Not Administer Pneumococcal Vaccine ☐ Administer ☐ Do Not Administer Influenza Vaccine *(Oct. - March only)*		
		15. ☐ Patient is a smoker or has smoked within the past year ☐ Patient advised not to smoke ☐ RN to provide smoking cessation education		

____ Practitioner

____ R.N. Time & Date: __________________________

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