



3901 Rainbow Blvd  
Kansas City, KS 66160

ADDRESSOGRAPH

MEDICATION SCHEDULE

bid 09-21 (alt 08-17) q2hours ODD or EVEN hours q12hours 09-21  
 tid 09-15-21 q6hours 00-06-12-18 (alt 01-13)  
 tid ac 07-11-17 (alt 09-15-21-03) qDAY 09 (alt 21)  
 tid pc 09-13-19 qid 09-13-17-21 q hs 21  
 tid w/meals 08-12-18 q8hours 06-14-22 (alt 09-17-01) ac hs 07-11-17-21

ROOM

All orders must be written in the metric system and must include date, time, physician's signature, and pager number.

NURSING:  
Fax to pharmacy.  
Record fax date/time.

ORDERS

Acute Spinal Cord Injury Routine Orders

(Page 1 of 4)

Rph  
Init

1. Admit to Nursing Unit:

Attending Physician:

Pager:

Resident Physician:

Pager:

2. Diagnosis: \_\_\_\_\_

3. Condition

4. Allergies:

5. Vital Signs q \_\_\_\_\_

6. Notify Spinal Cord Program Coordinator X87815 of admission (leave voice message)

7. Activity:

Spine Precautions: (choose one)

Full spine precautions

Cervical spine precautions only

Thoracic /lumbar/sacral (TLS) spine precautions (no cervical collar required)

Other: \_\_\_\_\_

8. Bracing: (Choose all that apply)

Cervical Collar -  Aspen Collar  Miami J<sup>®</sup> Collar (order from orthotics)

Wear collar when ambulating

Wear collar at all times

Thoracolumbosacral orthosis (TLSO) (order from orthotics)

TLSO on when out of bed

BRP & /or up in chair without TLSO

Wear TLSO at all times

9. Labs: \_\_\_\_\_

10. Initiate Spinal Cord Assessment sheet. (Xerox # NUR15B – 1052 or call 8-1550 to obtain)

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DATE & TIME	C m p #		Rph Init
		11. Neuro assessment per Spinal Cord Assessment sheet upon admission. Then q2 hours x 24	
		then q 4 hours. Reassess per Spinal Cord Injury Assessment Sheet after movement.	
		12. Respiratory:	
		<input type="checkbox"/> Incentive Spirometry q1hour when awake	
		<input type="checkbox"/> Initiate respiratory protocols	
		<input type="checkbox"/> Respiratory Treatments _____	
		13. <input type="checkbox"/> Ventilator Settings/ Oxygen device: _____	
		14. Mechanical DVT Prophylaxis: (choose all that apply)	
		<input type="checkbox"/> Sequential compression device to bilateral lower extremities when in bed	
		<input type="checkbox"/> TED hose to bilateral lower extremities	
		<input type="checkbox"/> Thigh / Calf measurements bid	
		<input type="checkbox"/> Consult interventional radiology for inferior vena cava filter (complete consult sheet)	
		15. Skin Integrity: (Note: Specialty bed/ mattresses must be ordered on specific order sheet)	
		<input type="checkbox"/> PRAFO[Pressure relieving ankle foot orthoses] splints to bilateral lower extremities (order from orthotics)	
		16. Bladder: Foley Catheter to DD	
		17. GI: (choose all that apply)	
		<input type="checkbox"/> No NG/orogastric tube	
		<input type="checkbox"/> NG/orogastric tube to low intermittent wall suction	
		<input type="checkbox"/> NG/orogastric tube to low continuous wall suction	
		<input type="checkbox"/> NPO	
		<input type="checkbox"/> NPO except po/NG/orogastric tube medications	
		<input type="checkbox"/> Diet _____	

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(Page 3 of 4)

DATE & TIME	Cmp #		Rph Init
		18. IV Fluids:	
		IV Fluids:	
		19. Consults:	
		<input type="checkbox"/> OT	
		<input type="checkbox"/> PT	
		<input type="checkbox"/> Rehab Medicine (complete consult sheet)	
		20. Call On-Call resident for:	
		<input type="checkbox"/> SBP <90 >150 mmHg	
		<input type="checkbox"/> HR <50 > 120 bpm	
		<input type="checkbox"/> Respiratory rate > 26	
		<input type="checkbox"/> SaO2 < 90%	
		<input type="checkbox"/> Any decrease in neurological status	
		<input type="checkbox"/> temp > 38.5	
		21. Nursing Care:	
		<input type="checkbox"/> Provide skin care with soap/ water and dry well under anterior & posterior cervical collar. Maintain strict spine alignment during collar care. Notify on call resident of new skin breakdown noted.	
		<input type="checkbox"/> Provide ROM to all extremities q 8 hours	
		<input type="checkbox"/> Turn and reposition q 2 hours	
		22. Medications:	
		<input type="checkbox"/> Neurosurgery Bowel Program (Xerox # NUR15B-1050) or obtain from Neuro ICU. (X 81550)	
		Methylprednisolone Protocol: (Choose one) <b>Weight : _____ kg</b>	
		<input type="checkbox"/> Methylprednisolone _____ mg (30 mg/kg )IV bolus, then _____ mg/hr (5.4 mg/kg/hr) IV x 23 hours	
		<input type="checkbox"/> Methylprednisolone _____ mg (30 mg/kg) IV bolus, then _____ mg/hr (5.4 mg/kg/hr) IV x 47 hours	
		<input type="checkbox"/> None	

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(Page 3 of 4)

