THE UNIVERSITY OF KANSAS HOSPITAL
KUMED
3901 Rainbow Boulevard
Kansas City, Kansas 66160

PHYSICIAN'S ORDER FORM

Do not write in this box

DT0017

PATIENT LABEL

DATE & TIME	#	CANCER TREATMENT OUTPATIENT (CTO) ADMISSION ORDERS
		Outpatient procedure services are provided when the treatment plan is well defined and there is no need to evaluate for further treatment or inpatient admission.
		Reference:
		Allergies:_____ **Patient Weight:** _____**kg**
	1.	**Admit to :** CTO bed (anticipated length of stay < 12 hours)
	2.	**Service:**_____ **Attending Physician:**_____ **Pager:**_____ **Fellow/Resident Physician /ARNP:**_____ **Pager:**_____
	3.	Nurse Clinician/Transplant Coordinator:_____ Pager:_____
	4.	Research studies:_____ Principal Investigator:_____
	5.	**Diagnosis/Reason for admission:** **ICD9 code:**
	6.	☐ **Autologous Transplant** ☐ **Allogeneic Transplant:** ☐ Related donor ☐ Matched Unrelated Donor ☐ Other ☐ Peripheral Stem Cell ☐ Bone Marrow ☐ Cord Blood Date of transplant:_____
	7.	**Activity:** ☐ Up as tolerated ☐ Bed rest with Bathroom Privileges ☐ Up with assist ☐ Bed rest
	8.	**Isolation (check all that apply):** ☐ Neutropenic Precautions ☐ BMT precautions (private & HEPA filter for allogenic transplants) ☐ Contact Isolation for _____ ☐ Respiratory Isolation (Droplet Precautions) for_____
	9.	**Diet:** ☐ Blood & Marrow Transplant/Neutropenic diet ☐ Regular diet ☐ Other diet:_____
	10.	**Vital Signs:** Every _____hours
	11.	**Nursing:** ☐ Accurate I & O ☐ FSBS every _____ ☐ Height & weight ☐ Central venous catheter(s) care ☐ Peripheral IV placement
	12.	**Respiratory Therapy:** Breathing Treatments _____ every ____ hours Oxygen Therapy: ☐ O2 per nasal canula @_____ L/min ☐ O2 per mask @ _____ L/min ☐ IS every ____ hours
	13.	**Laboratory:** (Order all labs as Stat except cultures.) ☐ CBC ☐ Differential ☐ PT/PTT ☐ INR ☐ LDH ☐ BMP ☐ CMP ☐ Phos ☐ Magnesium ☐ ABG ☐ Blood cultures x ___ ☐ Urine culture ☐ Sputum culture ☐ Wound culture ☐ _____ ☐ _____
	14.	**Radiology:** ☐ PCXR ☐ PA/LAT CXR ☐ CT ☐ Contrast ☐ MRI ☐ Ultrasound ☐ Other_____

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	15.	**Other Diagnostic Tests:** ☐ EKG ☐ Other_____
	16.	**Blood product support:** ☐ Transfuse ____ Unit(s) leukoreduced RBCs for hemoglobin < _____ ☐ Transfuse ____ Unit(s) apheresis platelets, leukocytes reduced for count < _____ ☐ Transfuse ____ Unit(s) of Fresh Frozen Plasma for PT > ____ INR >_____ PTT> ____ ☐ CMV Negative ☐ RBC, leukocytes reduced ☐ Irradiated ☐Sickle cell negative
	17.	**Pre-medications for blood products:** ☐ Acetaminophen 650mg po 30 minutes prior to transfusion. ☐ Diphenhydramine 25mg po or IV 30 minutes prior to transfusion
	18.	**Medications:** ☐ Antibiotics- See appropriate form
	19.	**IVF:**
	20.	**Other Medications:**
	21.	**Electrolyte Replacement Orders: (orders apply if creatinine < 2mg/dL. If ≥ 2, call physician/ARNP)** ☐ For K+ < 3.5 mEq/Liter, give KCl 40 mEq IV over 4 hours x 1. ☐ Repeat K+ level ☐ For Mg++ < 1.6mEq/Liter, give Magnesium Sulfate 2gm IV over 2 hours x 1. ☐ Repeat Mg++ level ☐ For PO4 ++ < 2.0 mg/dL, give NaPhos 8 mmol IVPB x 1. ☐ Repeat PO4++ level
	22.	**Call Physician /ARNP for any of the following:** Temp> 38.1°C, SBP>190 or < 90, DBP >100 or < 50, P> 120 or < 50, RR> 30 or < 10, SaO2 < 90% or Urine output< 30ml/hr.

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	23.	**Discharge orders/ instructions:**
	24.	**Discharge medications:**
	25.	**Follow-up appointments/instructions:** ☐ **RN** call Cancer Center Treatment or BMT area for **next day** appt ☐ **Pt** call Cancer Center scheduling @ 913-588-3671 for appt

Physician/ARNP Signature: _____ Pager: _____