





<p><b>THE UNIVERSITY OF KANSAS HOSPITAL</b>          3901 Rainbow Boulevard          Kansas City, Kansas 66160</p> <p><b>PHYSICIAN'S ORDER FORM</b></p>	<p><b>Do not write in this box</b></p>	<p><b>PATIENT LABEL</b></p>
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DATE & TIME	ORDERS TRANSPLANT, ADULT BLOOD & MARROW READMISSION ORDERS (Continued)	
13.	<b>Diagnostic Tests:</b>	<input type="checkbox"/> PCXR <input type="checkbox"/> PA/LAT CXR <input type="checkbox"/> ECG <input type="checkbox"/> CT <input type="checkbox"/> Chest <input type="checkbox"/> Chest/Abdomen/Pelvis <input type="checkbox"/> Head/Sinuses <input type="checkbox"/> Other: _____ <input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast <input type="checkbox"/> MRI <input type="checkbox"/> PET/CT <input type="checkbox"/> Other _____
14.	<b>Blood product support: ALL BLOOD PRODUCTS EXCEPT STEM CELLS MUST BE IRRADIATED AND LEUKOREduced – (Only Allogeneic transplant Recipients that are CMV negative and have a CMV negative donor require CMV negative products.)</b> <input type="checkbox"/> Transfuse 1 Unit PRBC for hemoglobin $\leq$ 7.0mg/dL or _____ <input type="checkbox"/> Transfuse 1 Unit Single Donor Platelets for platelet count $\leq$ 10,000/uL or _____	
	<b>Pre-medications for blood products:</b> <input type="checkbox"/> Acetaminophen 650 mg po x 1 dose to be given 30 minutes prior to transfusion. <input type="checkbox"/> Diphenhydramine 25 mg po or IV x 1 dose to be given 30 minutes prior to transfusion. <input type="checkbox"/> Other: _____	
15.	<b>IV Fluids:</b> _____	
16.	<b>Electrolyte Replacement Orders: <i>To be infused via a central line only</i></b> <ul style="list-style-type: none"> <li>• Standing order only applies for patients with a serum creatinine <math>\leq</math> 1.5 mg/dL. For patients with a serum creatinine <math>&gt;</math> 1.5 mg/dL, check with provider for further management.</li> <li>• For K<sup>+</sup> = 3.0-3.5 mEq/L, give KCl 40 mEq IV over 4 hours x 1.</li> <li>• For K<sup>+</sup> <math>&lt;</math> 3.0mEq/L, give KCl 60 mEq IV over 6 hours x 1 and check K<sup>+</sup> 30 minutes after completion. If repeat K<sup>+</sup> <math>&lt;</math> 3.5mEq/Liter, give KCl 40 mEq IV over 4 hours x 1 and notify physician/ARNP.</li> <li>• For Mg<sup>++</sup> <math>&lt;</math> 1.6mEq/L, give Magnesium Sulfate 4gm IV over 2 hours x 1</li> <li>• For PO<sub>4</sub> <sup>++</sup> <math>&lt;</math> 2.0 mg/dL, give NaPhos 8 mmol IVPB x 1</li> </ul>	
17.	<b>PRN medications:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Oxycodone 5-10mg po q 4 hr prn pain.</li> <li><input type="checkbox"/> Zolpidem 5mg po qhs prn insomnia. May repeat x 1.</li> <li><input type="checkbox"/> Lorazepam 0.5-1 mg po/IV q 6-8hr prn anxiety/nausea.</li> <li><input type="checkbox"/> Lansoprazole 30 mg po daily.</li> <li><input type="checkbox"/> Docusate 100-200mg po bid prn constipation. (1<sup>st</sup> choice for constipation).</li> <li><input type="checkbox"/> Senna 1-2 tabs po qhs prn constipation. (2<sup>nd</sup> choice for constipation).</li> <li><input type="checkbox"/> Magnesium/aluminum hydroxide 15 mL po q 4 hr prn dyspepsia.</li> <li><input type="checkbox"/> Alteplase 2 mg IV to central line prn no blood return/difficulty flushing (per protocol).</li> </ul>	



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**ORDERS**

**TRANSPLANT, ADULT BLOOD & MARROW READMISSION ORDERS (Continued)**

18.

**Febrile Management:**

- Notify Physician/ARNP for fever = or > 38.1° C oral (or 38.3° tympanic).
- For the first fever,
  - Obtain blood cultures (bacterial and fungal) from all central line lumens and one peripheral site (if possible).
  - Obtain sputum for culture/sensitivity if patient has productive cough
  - Obtain stool culture/sensitivity if indicated.
- For subsequent fevers, obtain only bacterial blood cultures from each catheter lumen and peripheral site within a 24-hour period or as ordered, x 3 days, then q 48 hours
- Obtain blood cultures before administration of acetaminophen or initiation of newly ordered antibiotics.
- Obtain culture for C. diff, if patient has > 3 loose stools in 24 hour period

19.

**Consults:**

- Central Venous Catheter Placement by: \_\_\_\_\_  
Type of central venous catheter: \_\_\_\_\_  
Date of Placement: \_\_\_\_\_  
Call service to notify of patient's arrival.
- Nutrition Consult
- Social Work Consult/ Needs Assessment

20.

**Notify Provider:**

Call Physician/ARNP: for 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.

Physician Signature: \_\_\_\_\_ Pager: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**TRANSPLANT, ADULT BLOOD & MARROW READMISSION ORDERS**

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