PHYSICIAN'S ORDERS

ADMISSION: LAC+USC Burn ICU	Weight:	Height:	Allergies/Specify Reactions:
Diagnosis: ______%TBSA **Inhalation injury:** ❒yes ❒ no **Other Diagnosis:** ________________________ **Past Medical History:** ____________________ **Condition:** ❒ Good ❒ Fair ❒ Serious ❒ Critical			

MONITORING

❒ Vital signs every hour
❒ **Adults – required assessment by MD for VTE risk**
❒ Insert foley catheter
❒ Strict In's and Outs every hour
❒ Bladder Pressure now for TBSA greater than 20% or 10% with inhalation, then follow protocol
❒ Pulse checks every hour Location__________________

DIAGNOSTICS

❒ Blood alcohol and Urine drug screening ❒ ABG, carboxyhemoglobin ❒ HCG pregnancy test
❒ CBC with differential, PTT, PT/INR, Complete Metabolic Panel, Magnesium, Phosphate, Pre-Albumin, CRP
❒ Type and cross, utilize Blood Product Form ❒ HgbA1C ❒ Hepatitis B, C (Ag, Ab)
❒ Nasal MRSA/ORSA culture ❒ Chest X-ray ❒ EKG

RESPIRATORY THERAPY

❒ Nasal Cannula O2 at ____Lpm or ❒ Aerosolized Face Mask O2 at _______% or ❒ Other _________@____
❒ High Frequency Percussinator Ventilation
Rate: _____ Frequency: ______ PIP:_____ PEEP:_______ CPAP:______ FiO2:______
❒ Conventional Ventilation
❒ SIMV ❒ PRVC ❒ AC ❒ PS ❒ PC ❒ APRV ❒ Other_______________
Rate: ______ Tv: _______PS: _____PEEP:_______ CPAP: _______FiO2:_______
❒ Chlorhexidine 0.12% oral liquid 15ml swish/spit q12h (use for all intubated patients)

INTRAVENOUS FLUIDS

❒ Maintenance Fluid: ___________________at ________mL/hour
❒ PARKLAND FLUID RESUSCITATION
(____%TBSA) X (_____kg) X 4 = _______mL; give 50% over first 8 hours, rest 50% over next 16 hours:
Lactated Ringers at ______mL per hour for first 8 hours; then _____ mL per hour for next 16 hours
❒ Call MD for urine output less than 0.5 mL/kg per hour
❒ Call MD for urine output less than 1 mL/kg per hour ❒ Call MD for urine output greater than 1 mL/kg per hour

MEDICATIONS: See attached

❒ PADI/Medication Reconciliation ❒ Pain/Sedation Order Form ❒ Vitamin Form ❒ Insulin Order Form
❒ Pharmacy Evaluation ❒ Other _____________________
❒ Adult VTE Risk Assessment and Prophylaxis Order Form **(Required-MD needs to fill out for all adults)**

ACTIVITY

❒ Physical Therapy Evaluation ❒ Occupational Therapy Evaluation
❒ Bedrest ❒ Elevate _______ extremities ❒ Restraints – Utilize Restraint Order sheet

NUTRITION

❒ Nutrition Consult ❒ Daily weights ❒ Insert NGT with KUB x-ray to verify placement ❒ Nutrition Order Form

WOUND CARE

❒ Medical Photography ❒ Utilize Pre-Printed Dressing Form

CONSULTS

❒ Ophthalmology ❒ Pediatric ❒ Social Work ❒ Pastoral Care ❒ Other ___________

SMOKING CESSATION (Core Measure):

If patient smokes, provide smoking cessation education and offer 1-800-NO-BUTTS (1-800-662-8887)

Date	Time Written	Physician's Signature		IMPRINT ID CARD (NAME MRUN CLINIC/WARD)
Physician's ID Number		Service		
RN's Signature		Date	Time	
		Scanned By		

PHYSICIAN'S ORDERS

BURN CENTER ICU ADMISSION ORDERS 7/2012