UMASS MEMORIAL MEDICAL CENTER

PHYSICIAN'S ORDERS
CHRONIC PANCREATITIS

Height	Weight
Inches ________ Cm. ________	Lbs. ________ Kg. ________
ALLERGIES: ☐ YES (LIST BELOW) OR ☐ LISTED PREVIOUSLY ☐ NONE KNOWN	

NAME:

ADDRESS:

BIRTHDATE/AGE: SEX:

MEDICAL RECORD NUMBER:

PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

3

PROVIDER TO SIGN AND PLACE PAGER NUMBER LEGIBLY UNDER EACH ORDER SET
INDICATE CHOICE OF ORDER OPTIONS BY USING X IN CHECK BOXES ☒

Attending/Change Attending To: ______________________ (First) ______________________ (Last) **Pager:** ________

Resident: ______________________ **Pager:** __________ **Overnight coverage:** ______________________ **Pager:** ________

Intern/NP/PA (First Call): ______________________ **Pager:** __________ **House Staff Coverage:** ☐ **Yes** ☐ **No (uncovered)**

ALL OTHER ORDERS	DATE	TIME	MEDICATION ORDERS ONLY
Diagnosis: Chronic Pancreatitis Day 1			See Medication Reconciliation Order Form for preadmission
Status: INPATIENT must meet **BOTH** of the following:			medications.
☐ Worsening abdominal pain			**New Admission Medications:**
☐ Unresponsive to >3 doses analgesia (includes PO) within last 24hrs			
NURSING:			
☐ Pulse Ox and vital signs every shift			**Glycemic Control:**
☐ Apply O2 NC to keep:			☒ Insulin and FSBS per Insulin Order Sheet
Please circle: O2sat > 92% ***or*** *O2sat 88-92%*			**DVT Prophylaxis:**
☐ Call provider if patient has temp >38.0°C, BP <90, HR <50 or >100			☐ Ambulate TID
☐ Call provider if patient leaves unit except for testing			☐ Enoxaparin 40mg subQ daily
Patient to remain on unit while on PCA for safety			☐ Enoxaparin 30mg subQ daily (for CrCl < 30mL/min)
Activity:			☐ Heparin 5000 units subQ every _____ hours
☐ Ambulate with assistance; advance activity per Nursing assessment			☐ Intermittent Pneumatic Compression Boots
☐ Out of bed ☐ Ambulate with assistance in hall 3x day			**Withdrawal:**
☐ Other:			☐ CIWA Protocol (complete CIWA form)
Diet: ☒ **NPO**			☐ See Nicotine Dependence Treatment Order Sheet
IV: Normal saline IVF ___________ at ____ mL/hr for _______			**Pain Control Regimen:**
Labs: ☒ CBC, BMP, Mag & Phos (if not done in ED)			**Note: Discontinue home opiate regimen**
☒ Amylase/Lipase/Albumin/Prealbumin (if not done in ED)			☒ PCA (complete PCA - form 810672)
☐ Hepatic Panel ☐ ALC blood alcohol level (if not done in ED)			☐ Gabapentin 300mg PO QHS x 48 hours then increase to
☒ UTOX urine tox screen (if not done in ED)			BID x 72 hours (recommended for patients who have no
☒ COHB Carboxyhemaglobin to assess for recent smoking			history of allergy or intolerance)
(if not done in ED)			**Bowel Regimen (recommended to order with opiods):**
Other: For Tracking Purposes			☐ Docusate 100mg PO BID
☐ Patient of the UMMMC Pancreatitis Clinic			☐ Senna ☐ 1 ☐ 2 tabs PO ☐ QHS ☐ BID
Has patient had confirmation of pancreatitis diagnosis by EUS,			PRN constipation
CT scan or secretion stimulation test? ☐ Yes ☐ No			☒ Miralax 17gm PO BID
Consults: ☐ Tobacco Cessation (for smokers unwilling to stop)			☐ Milk of Magnesia 10mL PO every 4 hours PRN constipation
☐ Gastroenterology (recommended for patients without confirmed diagnosis)			**Antiemetic:**
☒ Social Work			☐ Metoclopramide 10mg IV every 6 hours PRN nausea
☒ Health Psychology consult, Ext 62148			☐ Ondansetron 4mg IV every 8 hours PRN nausea
Advanced Directive:			
☐ Full Code			
☐ DNR (complete Orders for Limitation of Treatment Directives,			
form ID 810194)			

Signature of MD/DO/NP/PA:______________________ Printed Name:______________________ Pager:__________

Signature of RN: ______________________ Printed Name: ______________________ Date: ___________ Time: __________

Prohibited Abbreviations: U, qd, qod, IU, .1 (write 0.1), 1.0 (write 1), MS, MSO4, MgSO4

NS ORDER 0232 Rev 07/22/13

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Resident: ______________________ **Pager:** __________ **Overnight coverage:** ______________________ **Pager:** ________

Intern/NP/PA (First Call): ______________________ **Pager:** __________ **House Staff Coverage:** ☐ **Yes** ☐ **No (uncovered)**

ALL OTHER ORDERS	DATE	TIME	MEDICATION ORDERS ONLY
Diagnosis: Chronic Pancreatitis Day 2			See Medication Reconciliation Order Form for preadmission
			medications.
Notes:			**New or Changed Medications:**
No routine follow-up CBC, BMP, Mg, Phos, amylase, lipase			
recommended unless clinically indicated to follow a comorbid			
condition.			
Activity:			***All patients should be transitioned to oral pain management**
Note: encourage ambulation			***unless one of the below conditions exist (please check):***
☐ Out of bed to chair for all meals and toileting			☐ Unable to tolerate PO
☐ Other:			☐ Uncontrolled pain
Diet:			**Pain Control Regimen:**
Note: recommend advancing diet if pain improving			☐ D/C PCA and resume home pain regimen (MD must order
☐ Clear liquids			individual medications)
Consults:			
☐ Gastroenterology (consider if failing to improve)			
☐ PT (recommended if patient is not ambulating at baseline)			
☐ Other:			
REMINDER: Please plan for discharge now by obtaining PCP			
and Pancreatitis Clinic follow-up appointments.			

Signature of MD/DO/NP/PA:______________________ Printed Name:______________________ Pager:__________

Signature of RN: ______________________ Printed Name: ______________________ Date: ____________ Time: __________

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Resident: ______________________ **Pager:** __________ **Overnight coverage:** ______________________ **Pager:** ________

Intern/NP/PA (First Call): ______________________ **Pager:** __________ **House Staff Coverage:** ☐ **Yes** ☐ **No (uncovered)**

ALL OTHER ORDERS	DATE	TIME	MEDICATION ORDERS ONLY
Diagnosis: Chronic Pancreatitis Day 3			See Medication Reconciliation Order Form for preadmission
			medications.
☐ **Discharge** today as all the following stability criteria are met:			**New or Changed Medications:**
- Tolderating diet (able to tolerate > 300 mL of fluids			
- Pain controlled and converted to PO			
- Ambulating			
☐ Continue **Inpatient Admission** as above criteria not met			
			****All patients should be transitioned to oral pain management***
Activity:			***unless one of the below conditions exist (please check):***
Note: encourage ambulation			☐ Unable to tolerate PO
☐ Out of bed to chair for all meals and toileting			
☐ Other:			**Pain Control Regimen:**
			☒ D/C PCA and resume home pain regimen (MD must order
Diet:			individual medications)
☐ Low fat ☐ Clear liquids			
☐ Other:			***Note: If patient reports pain not controlled, contact Health***
			Psychology.
Labs:			
☐ COHB Carboxyhemaglobin (consider for smokers who are			
failing to improve)			
Consults:			
☐ Nutrition (recommended for patients < 300mL oral intake of fluids)			
☐ PT (recommended if patient is not ambulating at baseline)			

Signature of MD/DO/NP/PA:______________________ Printed Name:______________________ Pager:__________

Signature of RN: ______________________ Printed Name: ______________________ Date: ___________ Time: __________

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Resident: ______________________ **Pager:** __________ **Overnight coverage:** ______________________ **Pager:** ________

Intern/NP/PA (First Call): ______________________ **Pager:** __________ **House Staff Coverage:** ☐ **Yes** ☐ **No (uncovered)**

ALL OTHER ORDERS	DATE	TIME	MEDICATION ORDERS ONLY
Diagnosis: Chronic Pancreatitis Day 4			See Medication Reconciliation Order Form for preadmission
			medications.
☐ **Discharge** today as all the following stability criteria are met:			**New or Changed Medications:**
- Tolderating diet (able to tolerate > 300 mL of fluids			
- Pain controlled and converted to PO			
- Ambulating			
☐ Continue **Inpatient Admission** as the following criteria not			
met: ______________________			
Activity:			
Note: encourage ambulation			
☐ Out of bed to chair for all meals and toileting			
☐ Other:			
Diet:			
☐ Low fat ☐ Clear liquids			
☐ Other:			
Labs:			
☐ COHB Carboxyhemaglobin (consider for smokers who are			
failing to improve)			
Consults:			
☐ Nutrition (recommended for patients < 300mL oral intake of fluids)			
☐ PT (recommended if patient is not ambulating at baseline)			

Signature of MD/DO/NP/PA:______________________ Printed Name:______________________ Pager:__________

Signature of RN: ______________________ Printed Name: ______________________ Date: ___________ Time: __________

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