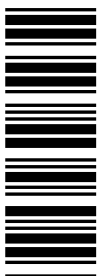


SEND TO PHARMACY
IMMEDIATELY

Please check the box to the left of the appropriate facility:
 Pitt County Memorial Hospital Roanoke-Chowan Hospital Brody School of Medicine at East Carolina University
 Bertie Memorial Hospital SurgiCenter Services of Pitt The Outer Banks Hospital
 Chowan Hospital Heritage Hospital

DATE	HOUR	NURSES NOTATIONS	ORDERS:
			NUR: STROKE / TIA ADMISSION HS# 100121
			ADMISSION / TRANSFER / INFORMATION:
			Admit to: _____ (Service) Status: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Observation / Outpatient
			Attending Physician:
			<input type="checkbox"/> General Bed <input type="checkbox"/> Medical Intermediate (MIU) <input type="checkbox"/> General Monitored Bed – Cardiac Monitor <input type="checkbox"/> Medical Intensive Care Unit (MICU) <input type="checkbox"/> Monitored Bed <input type="checkbox"/> NIU (2 South) <input type="checkbox"/> Other: _____
			Primary Diagnosis: Stroke / Transient Ischemic Attack
			NIHSS Score: _____ <input checked="" type="checkbox"/> Patient is NOT an IV t-PA Candidate: Reason _____
			Secondary Diagnoses: Comorbidities (Please List):
			<input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____
			CODE STATUS: Implement End of Life/ Patient Care Orders (Form # 7025 REQUIRED)
			Venous ThromboEmbolism Assessment: DVT / VTE
			<input type="checkbox"/> Patient AT Risk : <input type="checkbox"/> Prophylaxis included in these admission orders <input type="checkbox"/> Prophylaxis Contraindicated: _____ (List Contraindication) <input type="checkbox"/> Patient NOT at Risk
			VITAL SIGNS:
			<input type="checkbox"/> Vital Signs every <input type="checkbox"/> 1 hour <input type="checkbox"/> 2 hours <input type="checkbox"/> 4 hours
			Notify Provider for any of the following parameters:
			<input type="checkbox"/> Standard <input type="checkbox"/> Custom
			<ul style="list-style-type: none"> • Temperature > 38.1°C • Systolic Blood Pressure > 220 or < 100mmHg • Diastolic Blood Pressure > 120 or < 70mmHg • Heart Rate > 120 or < 60 per minute • Respirations > 30 or < 10 per minute • Urine output < 30 mL / hour • Neurological deterioration
			<ul style="list-style-type: none"> • Temperature > _____°C • Systolic Blood Pressure > _____ or < _____ mmHg • Diastolic Blood Pressure > _____ or < _____ mmHg • Heart Rate > _____ or < _____ per minute • Respirations > _____ or < _____ per minute • Urine output < _____ mL / hour • Neurological deterioration
			ACTIVITY:
			<input type="checkbox"/> Bed Rest <input type="checkbox"/> As tolerated <input type="checkbox"/> Mobility Protocol
			<input type="checkbox"/> Ambulate with assistance <input type="checkbox"/> Do NOT pull on affected side <input type="checkbox"/> Other: _____
			<input type="checkbox"/> Bed Rest X 24 hours, then up with assistance

M.D. / _____ Physician # / _____ Pager #



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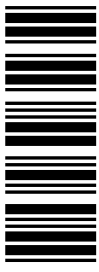
- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Pitt County Memorial Hospital | <input type="checkbox"/> Roanoke-Chowan Hospital | <input type="checkbox"/> Brody School of Medicine at East Carolina University |
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| <input type="checkbox"/> Chowan Hospital | <input type="checkbox"/> Heritage Hospital | |

DATE	HOUR	NURSES NOTATIONS	ORDERS:																								
			NUR: STROKE / TIA ADMISSION HS# 100121																								
			ALLERGIES (List Reaction) <input type="checkbox"/> No Known Drug Allergies (NKDA)																								
			NURSING:																								
			<input checked="" type="checkbox"/> Plan of Care – Stroke <input checked="" type="checkbox"/> Intake and Output every shift X 48 hours <input checked="" type="checkbox"/> Implement the following precautions: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> None </div> <div> <input type="checkbox"/> Seizure </div> <div> <input type="checkbox"/> Skin Integrity </div> </div> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Bleeding </div> <div> <input type="checkbox"/> Fall </div> <div> <input type="checkbox"/> Other: _____ </div> </div> <input checked="" type="checkbox"/> Measure and Record weight daily <input checked="" type="checkbox"/> Dysphagia Screen Dysphagia Screen <input checked="" type="checkbox"/> NIHSS every 4 hours X 24 hours, then every shift until discharge <input type="checkbox"/> Foley catheter to gravity <input type="checkbox"/> Discontinue Foley catheter after 24 hours <input type="checkbox"/> Condom Catheter <input type="checkbox"/> Head of Bed elevated 30 degrees <input type="checkbox"/> Head of Bed elevated _____ degrees <input checked="" type="checkbox"/> Neuro Checks per Frequency and Parameters below: <table style="width:100%; border:none;"> <tr> <td style="text-align:center"><u>Frequency</u></td> <td style="text-align:center"><u>Parameters</u></td> </tr> <tr> <td><input type="checkbox"/> Every 1 hour</td> <td><input type="checkbox"/> Glasgow Coma Scale</td> </tr> <tr> <td><input type="checkbox"/> Every 2 hours</td> <td><input type="checkbox"/> Pupils</td> </tr> <tr> <td><input type="checkbox"/> Every 4 hours</td> <td><input type="checkbox"/> Sensation</td> </tr> <tr> <td><input type="checkbox"/> Every 8 hours</td> <td><input type="checkbox"/> Speech</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Strength</td> </tr> </table> <input checked="" type="checkbox"/> Nurse to provide patient / family education on: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Diabetic teaching</td> <td><input checked="" type="checkbox"/> Stroke Education</td> <td><input checked="" type="checkbox"/> 911 –EMS</td> <td><input type="checkbox"/> Other:</td> </tr> <tr> <td><input type="checkbox"/> Diet</td> <td><input checked="" type="checkbox"/> Warning Signs</td> <td><input checked="" type="checkbox"/> Follow-up</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Lifestyle changes</td> <td><input checked="" type="checkbox"/> Risk Factors</td> <td><input checked="" type="checkbox"/> Medications</td> <td></td> </tr> </table>	<u>Frequency</u>	<u>Parameters</u>	<input type="checkbox"/> Every 1 hour	<input type="checkbox"/> Glasgow Coma Scale	<input type="checkbox"/> Every 2 hours	<input type="checkbox"/> Pupils	<input type="checkbox"/> Every 4 hours	<input type="checkbox"/> Sensation	<input type="checkbox"/> Every 8 hours	<input type="checkbox"/> Speech		<input type="checkbox"/> Strength	<input type="checkbox"/> Diabetic teaching	<input checked="" type="checkbox"/> Stroke Education	<input checked="" type="checkbox"/> 911 –EMS	<input type="checkbox"/> Other:	<input type="checkbox"/> Diet	<input checked="" type="checkbox"/> Warning Signs	<input checked="" type="checkbox"/> Follow-up		<input type="checkbox"/> Lifestyle changes	<input checked="" type="checkbox"/> Risk Factors	<input checked="" type="checkbox"/> Medications	
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			GI Tubes: <input type="checkbox"/> Nasogastric (NG) <input type="checkbox"/> Orogastric (OG) <input type="checkbox"/> Naso-Intestinal																								
			GI Tube Suction: <input type="checkbox"/> Gravity <input type="checkbox"/> Low Wall <input type="checkbox"/> Other:																								
			Mechanical Ventilation:																								
			<input type="checkbox"/> See Mechanical Ventilation Order Set																								

M.D. / _____

Physician # / _____

Pager # _____



2071 2930

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			NUR: STROKE / TIA ADMISSION HS# 100121																				
			<input type="checkbox"/> Tobacco Cessation Education (if tobacco use in past year) <ul style="list-style-type: none"> • Provide Education and Handout Materials • Tobacco Cessation Video • Tobacco Cessation Counselor referral <i>(Nurse to make referral as appropriate)</i> 																				
			Choose ONE Mechanical VTE Prophylaxis:																				
			<input type="checkbox"/> Sequential Compression Devices (SCD) <input type="checkbox"/> Arterio-Venous Impulse Pump (Foot Pump)																				
			DIET:																				
			<input type="checkbox"/> NPO <input type="checkbox"/> NPO Until Swallow Screen Performed																				
			<input type="checkbox"/> Diet As Tolerated, as Indicated by results of Swallow Screen																				
			<input type="checkbox"/> Enteral Tube Feeds <input type="checkbox"/> Other:																				
			<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Product:</th> <th style="width: 40%;">Strength:</th> <th style="width: 15%;">Amount:</th> <th style="width: 20%;">Time/Frequency:</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td><input type="checkbox"/> 1/4 <input type="checkbox"/> 1/2 <input type="checkbox"/> 3/4 <input type="checkbox"/> Full</td> <td>_____ ml</td> <td>_____</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Additional Protein Powder:</td> <td>_____ scoops</td> <td>_____</td> </tr> <tr> <td>Flush with:</td> <td><input type="checkbox"/> Water <input type="checkbox"/> Saline <input type="checkbox"/> Gatorade</td> <td>_____ ml</td> <td>_____</td> </tr> </tbody> </table>	Product:	Strength:	Amount:	Time/Frequency:	_____	<input type="checkbox"/> 1/4 <input type="checkbox"/> 1/2 <input type="checkbox"/> 3/4 <input type="checkbox"/> Full	_____ ml	_____	<input type="checkbox"/> Additional Protein Powder:		_____ scoops	_____	Flush with:	<input type="checkbox"/> Water <input type="checkbox"/> Saline <input type="checkbox"/> Gatorade	_____ ml	_____				
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			IV FLUIDS: (Place IV on unaffected Side, if possible)																				
			<input type="checkbox"/> Normal Saline at 75 mL / hour <input type="checkbox"/> Saline Lock <input type="checkbox"/> _____ @ _____ mL / hour																				
			SCHEDULED MEDICATIONS:																				
			Choose Pharmacological VTE Prophylaxis: (May select one or two medications)																				
			<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Medication</th> <th style="width: 15%;">Dose</th> <th style="width: 10%;">Route</th> <th style="width: 15%;">Frequency</th> <th style="width: 30%;">Indication</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Heparin</td> <td>_____ units</td> <td>SubQ</td> <td>Every 8 hours</td> <td>VTE Prophylaxis</td> </tr> <tr> <td><input type="checkbox"/> Enoxaparin (LOVENOX)</td> <td>40 mg</td> <td>SubQ</td> <td>Once Daily</td> <td>VTE Prophylaxis</td> </tr> <tr> <td><input type="checkbox"/> Warfarin (COUMADIN)</td> <td>_____ mg</td> <td>Oral</td> <td>Once daily</td> <td>VTE Prophylaxis</td> </tr> </tbody> </table>	Medication	Dose	Route	Frequency	Indication	<input type="checkbox"/> Heparin	_____ units	SubQ	Every 8 hours	VTE Prophylaxis	<input type="checkbox"/> Enoxaparin (LOVENOX)	40 mg	SubQ	Once Daily	VTE Prophylaxis	<input type="checkbox"/> Warfarin (COUMADIN)	_____ mg	Oral	Once daily	VTE Prophylaxis
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<input type="checkbox"/> Warfarin (COUMADIN)	_____ mg	Oral	Once daily	VTE Prophylaxis																			
			<input type="checkbox"/> Implement Heparin Protocol (Physician must complete Heparin Order Set)																				
			<p>*Unfractionated Heparin IV or LMWH subQ have not been of proven efficacy in completed stroke situations. Acceptable indicators for short-term empiric heparinization include progressive stroke, crescendo TIAs, arterial dissection, cerebral venous thrombosis, atrial fibrillation, hypercoagulable states, known cardiac embolic source, or vertebrobasilar thrombosis.</p>																				

M.D. / _____

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DATE	HOUR	NURSES NOTATIONS	ORDERS:				
			NUR: STROKE / TIA ADMISSION HS# 100121				
BPA: If TPA has been given: PROVIDER to confirm CT scan has been completed BEFORE Administration of Antithrombotic Medication			Antiplatelet Therapy:				
			Medication	Dose	Route	Frequency	
			<input type="checkbox"/> Enteric Coated Aspirin (ECASA)	81 mg	Oral	Once Daily (with food)	
			<input type="checkbox"/> Enteric Coated Aspirin (ECASA)	325 mg	Oral	Once Daily	
			<input type="checkbox"/> Clopidogrel (PLAVIX)	75 mg	Oral	Once Daily (in A.M.)	
			<input type="checkbox"/> Aspirin 25mg / Dipyridamole 200 mg (AGGRENOX)	1 tablet	Oral	Twice Daily	
			Blood Pressure Control:				
			Medication	Dose	Route	Frequency	Indcation
			<input type="checkbox"/> Labetalol (TRANDATE)	_____ mg / min	IV	Continuous Infusion	Blood Pressure Control
			Titrte infusion for: Systolic Blood Pressure: _____ Mean Arterial Pressure: _____				
			<input type="checkbox"/> Nicardipine (CARDENE)	2.5 mg – 15 mg	IV	Continuous Infusion	Blood Pressure Control
			Titrte infusion for: Systolic Blood Pressure: _____ Mean Arterial Pressure: _____				
			<input type="checkbox"/> Diltiazem (CARDIZEM)	_____ mg / hour	IV	Continuous Infusion	Blood Pressure Control
			Titrte Infusion for Systolic Blood Pressure: _____ Mean Arterial Pressure: _____				
			Anticonvulsant:				
			Medication	Dose	Route		Frequency
			<input type="checkbox"/> Fosphenytoin (CEREBYX) 15 – 20 mg / kg LOADING DOSE	_____ mg	IV		ONCE, then discontinue
			<input type="checkbox"/> Fosphenytoin – MAINTENANCE	_____ mg	IV		Every _____ hours
			<input type="checkbox"/> Phenytoin (DILANTIN) 15 – 20 mg / kg	_____ mg	<input type="checkbox"/> Oral OR gastric tube	<input type="checkbox"/> IV	ONCE, then discontinue
			<input type="checkbox"/> Phenytoin (DILANTIN) - MAINTENANCE	_____ mg	<input type="checkbox"/> Oral OR gastric tube	<input type="checkbox"/> IV	Every _____ hours
			<input type="checkbox"/> Valproic acid (DEPAKENE)	_____ mg	<input type="checkbox"/> Oral OR gastric tube	<input type="checkbox"/> IV	Every _____ hours
			<input type="checkbox"/> Levetiracetam (KEPPRA)	_____ mg	<input type="checkbox"/> Oral OR gastric tube	<input type="checkbox"/> IV	Every _____ hours
			<input type="checkbox"/> Phenobarbital	_____ mg	<input type="checkbox"/> Oral OR gastric tube	<input type="checkbox"/> IV	Every _____ hours

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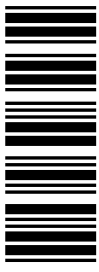
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DATE	HOUR	NURSES NOTATIONS	ORDERS:				
			NUR: STROKE / TIA ADMISSION			HS# 100121	
			Peptic Ulcer Prophylaxis:				
			Choose ONE for Peptic Ulcer Prophylaxis:				
			Medication	Dose	Route	Frequency	
			<input type="checkbox"/> Famotidine (PEPCID)	20 mg	Oral OR gastric tube	Twice Daily	
			<input type="checkbox"/> Famotidine (PEPCID)	20 mg	Oral OR gastric tube	ONCE Daily – CrCl < 50 mL / minute	
			<input type="checkbox"/> Esomeprazole (NEXIUM)	20 mg	IV	Once Daily	
			Sedation For Provider Use ONLY:				
			<input type="checkbox"/> Propofol (DIPRIVAN) 1% - 10mg/ mL	_____ mg	IV	For Physicians during procedure	
			Propofol Instructions:	Administered by PHYSICIANS ONLY			
			<input type="checkbox"/> Dexmedetomidine (PRECEDEX)	_____ mg	IV	For Physicians during procedure	
			Dexmedetomidine Instructions:	Administered by PHYSICIANS ONLY			
			OTHER MEDICATIONS:				
			Medication	Dose	Route	Frequency	
			<input type="checkbox"/> Nimodipine (NIMOTOP)	60 mg	Oral OR gastric tube	Every 4 hours	
			<input type="checkbox"/> Docusate (COLACE)	100 mg	Oral OR gastric tube	Twice Daily	
			<input type="checkbox"/> Senna (SENEKOT)	17.2 mg	Oral OR gastric tube	Once at Bedtime	
			<input type="checkbox"/> Mannitol (OSMITROL) 25% LOADING DOSE	_____ Gram	IV	ONCE, then discontinue	
			<input type="checkbox"/> Mannitol (OSMITROL) 25% 0.25 Grams – 1 Gram / kg MAINTENANCE	_____ Gram	IV	Every _____ hours	
			Mannitol Instructions:	Discontinue Mannitol for serum osmolarity > 310 mOsm / kg OR when _____ grams infused MAXIMUM = 2 Grams / kg / dose AND 6 grams / kg / 24 hours			
			<input type="checkbox"/> Lorazepam (ATIVAN)	_____ mg	Oral OR gastric tube	Every _____ hours	
			<input type="checkbox"/> Haloperadol (HALDOL)	_____ mg	Oral OR gastric tube	Every _____ hours	
			<input type="checkbox"/> Fentanyl	_____ mcg	Topical Patch	Change patch every ___ day	
			<input type="checkbox"/> Midazolam (VERSED)	_____ mg	IV	Every _____ hours	
			<input type="checkbox"/> Metaclopramide (REGLAN)	_____ mg	<input type="checkbox"/> Oral /gastric Tube <input type="checkbox"/> IV	Every _____ hours	

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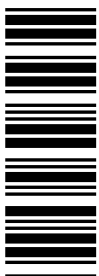
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			Medication	Dose	Route	Frequency	Indication	
			<input type="checkbox"/> See Additional Medication Orders on ADDENDUM					
			PRN MEDICATIONS:					
			Medication	Dose	Route	Frequency	PRN Indication	
			<input checked="" type="checkbox"/> Acetaminophen (TYLENOL)	650 mg	Oral	PRN Every 4 hours	Temp > 38.1°C	
			<input checked="" type="checkbox"/> Zolpidem (AMBIEN)	5 mg	Oral	PRN At Bedtime	Insomnia	
			<input checked="" type="checkbox"/> Docusate (COLACE)	100 mg	Oral	PRN Twice Daily	Constipation	
			<input checked="" type="checkbox"/> Senna	17.2 mg	Oral	PRN At Bedtime	Constipation	
			<input type="checkbox"/> Labetalol (TRANDATE) Max Dose: 300 mg / 24 hours	10-20 mg	IV	PRN Every _____	Systolic Blood Pressure > _____ Or Mean Arterial Pressure > _____	
			<input type="checkbox"/> Hydralazine (APRESOLINE)	5 – 10 mg	IV	PRN Every _____	Systolic Blood Pressure > _____ Or Mean Arterial Pressure > _____	
			<input type="checkbox"/> Morphine	1-4 mg	IV	PRN Every _____	Pain	
			<input type="checkbox"/> Midazolam (VERSED)	_____ mg	IV	PRN Every _____	Pain	
			Medications	Dose	Route		Frequency	PRN Indication
			<input type="checkbox"/> Ondansetron (ZOFTRAN)	_____ mg	<input type="checkbox"/> Oral or Gastric Tube	<input type="checkbox"/> IV	PRN Every _____	Nausea / Vomiting
			<input type="checkbox"/> Lorazepam (ATIVAN)	_____ mg	<input type="checkbox"/> Oral or Gastric Tube	<input type="checkbox"/> IV	PRN Every _____	Anxiety / Agitation
			<input type="checkbox"/> Haloperidol (HALDOL)	_____ mg	<input type="checkbox"/> Oral or Gastric Tube	<input type="checkbox"/> IV	PRN Every _____	Anxiety / Agitation

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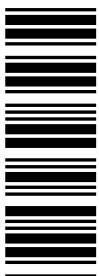
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<input type="checkbox"/> Partial Prothromboplastin Time (PTT)	<input type="checkbox"/> Comprehensive Metabolic Panel	<input type="checkbox"/> Troponin I																			
<input type="checkbox"/> CBC with platelets	<input type="checkbox"/> Hemoglobin A1C	<input type="checkbox"/> Urinalysis																			
<input type="checkbox"/> Creatine Kinase MB (CKMB)	<input type="checkbox"/> Glucose (Fasting)	<input type="checkbox"/> Culture, Urine																			
<input type="checkbox"/> Cardiac Panel	<input type="checkbox"/> Type and Screen																				
			RADIOLOGY and OTHER STUDIES: (Must Complete Radiology Request Form)																		
			<input type="checkbox"/> Carotid Duplex Imaging																		
			<input type="checkbox"/> Computed Tomography (CT) <input type="checkbox"/> WITH contrast <input type="checkbox"/> WithOUT contrast																		
			<input type="checkbox"/> Computed Tomography Arteriogram (CTA) - Brain <input type="checkbox"/> INTRAcranial <input type="checkbox"/> EXTRAcranial																		
			<input type="checkbox"/> Echocardiogram (Must complete Echocardiogram Order Set)																		
			<input type="checkbox"/> Electrocardiogram (ECG) – 12 lead (If not done in Emergency Department)																		
			<input type="checkbox"/> Electroencephalogram (EEG) <input type="checkbox"/> STAT <input type="checkbox"/> Routine <input type="checkbox"/> 24 hour <input type="checkbox"/> 48 hour																		
			<input type="checkbox"/> Magnetic Resonance (MRI) - Brain <input type="checkbox"/> WITH contrast <input type="checkbox"/> WithOUT contrast																		
			<input type="checkbox"/> Magnetic Resonance (MRA) – Brain <input type="checkbox"/> INTRAcranial <input type="checkbox"/> EXTRAcranial																		
			<input type="checkbox"/> Magnetic Resonance (MRA) – Neck																		
			CONSULTS:																		
			<input type="checkbox"/> Physical Therapy to evaluate and treat <input type="checkbox"/> Occupational Therapy to evaluate and treat <input type="checkbox"/> Dietitian to assess and recommend																		
			<input type="checkbox"/> Speech Therapy: <input type="checkbox"/> Speech / Language / Cognitive evaluation and treatment <input type="checkbox"/> Bedside Swallow Evaluation with follow up instrumental evaluation (as indicated)																		
			<input type="checkbox"/> Inpatient Case Manager for discharge planning <input type="checkbox"/> Pharmacy for Warfarin (COUMADIN) Counseling																		
			<input type="checkbox"/> PCMH Rehab for transfer evaluation on hospital day 3 (if appropriate): <input type="checkbox"/> Neuro Rehab: East Carolina Neurology <input type="checkbox"/> Physical Medicine Rehab: Brody SOM (ECU)																		
			<input type="checkbox"/> Acute Stroke Nurse to assist with Best Practice Guidelines																		
			<input type="checkbox"/> Acute Stroke Nurse Practitioner to assist with Best Practice Guidelines																		
			<input type="checkbox"/> Other:																		

M.D. / _____

Physician # / _____

Pager # _____



2071 2930

PHYSICIAN ORDERS

Patient ID

SEND TO PHARMACY
IMMEDIATELY

Please check the box to the left of the appropriate facility:

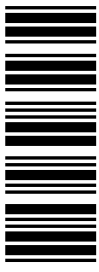
- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Pitt County Memorial Hospital | <input type="checkbox"/> Roanoke-Chowan Hospital | <input type="checkbox"/> Brody School of Medicine at East Carolina University |
| <input type="checkbox"/> Bertie Memorial Hospital | <input type="checkbox"/> SurgiCenter Services of Pitt | <input type="checkbox"/> The Outer Banks Hospital |
| <input type="checkbox"/> Chowan Hospital | <input type="checkbox"/> Heritage Hospital | |

Tested Item	Title	Responses	SCORES
1A	Level of Consciousness	0 – alert 1 – drowsy 2 – obtunded 3 – coma/unresponsive	_____
1B	Orientation questions (two)	0 -- answers both correctly 1 – answers one correctly 2 – answers neither correctly	_____
1C	Response to commands (two)	0 – performs both tasks correctly 1 – performs one task correctly 2 – performs neither	_____
2	Gaze	0 – normal horizontal movements 1 – partial gaze palsy 2 – complete gaze palsy	_____
3	Visual Fields	0 – no visual field defect 1 – partial hemianopia 2 – complete hemianopia 3 – bilateral hemianopia	_____
4	Facial movement	0 – normal 1 – minor facial weakness 2 – partial facial weakness 3 – complete unilateral palsy	_____
5	Motor functions (arm) a. Left b. Right	0 – no drift 1 – drift before 5 seconds 2 – falls before 10 seconds 3 – no effort against gravity 4 – no movement	L _____ R _____
6	Motor function (leg) a. Left b. Right	0 – no drift 1 – drift before 5 seconds 2 – falls before 5 seconds 3 – no effort against gravity 4 – no movement	L _____ R _____
7	Limb ataxia	0 – no ataxia 1 – ataxia in one limb 2 – ataxia in two limbs	_____

M.D. / _____

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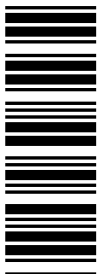
8	Sensory	0 – no sensory loss 1 – mild sensory loss 2 – severe sensory loss	_____
9	Language	0 – normal 1 – mild aphasia 2 – severe aphasia 3 – mute or global aphasia	_____
10	Articulation	0 – normal 1 – mild dysarthria 2 – severe dysarthria	_____
11	Extinction or inattention	0 – absent 1 – mild (loss 1 sensory modality) 2 – severe (loss 2 modalities)	_____
TOTAL SCORE:			_____

Completed by:

Date: _____ **Time:** _____

Signature: _____

_____ M.D. / _____ Physician # / _____ Pager #



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- Pitt County Memorial Hospital Roanoke-Chowan Hospital Brody School of Medicine at East Carolina University
- Bertie Memorial Hospital SurgiCenter Services of Pitt The Outer Banks Hospital
- Chowan Hospital Heritage Hospital

Dysphagia Screen

A Dysphagia Screen may be performed on admission or during the hospital stay for any patient suspected of swallowing difficulty.

Dysphagia Screen: Patient must be:

- 1) Alert 2) Able to participate 3) Able to sit upright (90 degrees preferred) for 30 minutes.

If not, keep NPO until criteria met.

Does the patient have a confirmed diagnosis by a physician or a history of any of the following disorders:

- 1) Brainstem Stroke 5) Myasthenia Gravis 8) Moderate to Severe Unilateral Stroke
- 2) Bilateral Strokes 6) Laryngeal Trauma 9) Current Aspiration Pneumonia
- 3) Parkinson’s Disease 7) Oral and/or Laryngeal Cancer 10) Recurring Aspiration Pneumonia
- 4) Failure to Thrive

Yes

No

Does the patient exhibit any CLINICAL FACTORS associated with Dysphagia:

- 1) Moderate to severe slurred speech 4) abnormal voice 7) weak or absent gag
- 2) Wet or gurgly voice or breath sounds 5) inability to manage secretions 8) cough after swallow
- 3) Significant facial or lingual weakness 6) weak or absent cough 9) tracheostomy tube

Yes

No

Does the patient or patient’s family report difficulty swallowing:

- 1) “food gets stuck” 2) “strangling” or “choking” 3) inability to swallow 4) painful swallowing.

Yes

No

If all boxes checked NO, administer 10 cc of water from a cup (no straws) and observe. Does patient exhibit:

- 1) wet, gurgly voice 2) cough after swallow 3) throat clearing 4) watery eyes 5) runny nose

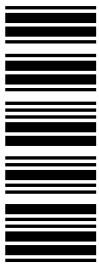
Yes

No

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- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Pitt County Memorial Hospital | <input type="checkbox"/> Roanoke-Chowan Hospital | <input type="checkbox"/> Brody School of Medicine at East Carolina University |
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If **ALL** boxes are checked **No**, Contact MD for diet order, including restrictions (ie low sodium, low fat). Recommend appropriate texture based on status of dentition (pureed diet, mech soft diet, soft to chew diet). Request dietary consult.

If **ANY** boxes are checked **Yes**, patient is to remain NPO. Contact MD for order to obtain a Speech Consult for Bedside Swallow Evaluation. Evaluations will be conducted between 0730 and 1600 seven days a week.

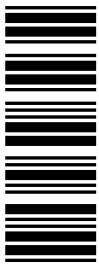
Department of Speech Pathology 847-4448.

**IF PATIENT EXHIBITS NEURO CHANGES, REPEAT DYSPHAGIA SCREEN.
RECOMMEND BEDSIDE SWALLOW EVAL IF THERE ARE ANY CONCERNS.**

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207/ 2930

PHYSICIAN ORDERS

Patient ID