



T H E
FREMONT-RIDEOUT
 H E A L T H G R O U P

**CRITICAL CARE
 TRANSFER ORDERS**

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IMPRINT PATIENT PLATE WITHIN THIS BOX

FAX ORDERS TO PHARMACY ASAP

Admit Date:	Transfer Date:	Diagnosis:
Allergies:		
Transfer to: <input type="checkbox"/> Intermediate Care <input type="checkbox"/> Telemetry <input type="checkbox"/> Surgical <input type="checkbox"/> Medical <input type="checkbox"/> OCP		
<input type="checkbox"/> MD Consultants		
Code Status:		
<input type="checkbox"/> Modified Code Status: Check Box for Yes		
<input type="checkbox"/> Full Code <input type="checkbox"/> Defibrillation <input type="checkbox"/> Chest Compressions <input type="checkbox"/> Intubation		
<input type="checkbox"/> Do Not Resuscitate <input type="checkbox"/> Assisted Ventilation <input type="checkbox"/> ACLS Drug Protocol		
Vital Signs:		
Per Routine Q Shift unless on Telemetry Q4 <input type="checkbox"/> Daily Weight <input type="checkbox"/> Intake & Output Q Shift		
IV Fluids:		
<input type="checkbox"/> Saline Lock <input type="checkbox"/> D5NS <input type="checkbox"/> D5LR <input type="checkbox"/> D5 ½ NS at _____ ml/hour add <input type="checkbox"/> 40 meq KCL/L		
Oxygen saturation checks and Respiratory Treatments:		
<input type="checkbox"/> Titrate O ₂ per nasal cannula to keep saturation greater than or equal to _____		
<input type="checkbox"/> If O ₂ saturation less than _____ on _____ liters oxygen, call MD		
<input type="checkbox"/> Incentive Spirometer Q4H & PRN while awake		
<input type="checkbox"/> SVNs <input type="checkbox"/> IPPB <input type="checkbox"/> Albuterol _____ mg <input type="checkbox"/> Atrovent _____ mg		
<input type="checkbox"/> Xopenex _____ mg <input type="checkbox"/> Mucomyst _____ mg		
<input type="checkbox"/> Q4H, <input type="checkbox"/> Q6H, <input type="checkbox"/> Q12H, <input type="checkbox"/> PRN Q _____ HRS Wheezing or SOB		
Diet:		
<input type="checkbox"/> NPO <input type="checkbox"/> Dubhoff Tube Feeding <input type="checkbox"/> Optimal <input type="checkbox"/> Glucerna <input type="checkbox"/> Nepro <input type="checkbox"/> Jevity with fiber		
<input type="checkbox"/> Clear Liquids <input type="checkbox"/> Full Liquids <input type="checkbox"/> Mechanical Soft <input type="checkbox"/> Dysphagia 1 or 2 <input type="checkbox"/> Regular		
<input type="checkbox"/> ADA _____ Cal <input type="checkbox"/> NO Salt Added <input type="checkbox"/> Fluid Restriction of _____		
<input type="checkbox"/> TPN <input type="checkbox"/> Standard <input type="checkbox"/> Renal <input type="checkbox"/> Hepatic at 20cc / Hr <input type="checkbox"/> 20% Lipids at 20cc / Hr		
<input type="checkbox"/> Dietary Consult Further adjustments are to be determined by dietician		
<input type="checkbox"/> Keep HOB at 30° or: _____ <input type="checkbox"/> NG to suction – Avoid gastric distention; call MD if abdomen increases in size		
Activity:		
<input type="checkbox"/> Flat in bed <input type="checkbox"/> Bed Rest <input type="checkbox"/> Dangle <input type="checkbox"/> Chair with assistant <input type="checkbox"/> Ambulate with assistant <input type="checkbox"/> Bathroom Privileges		
<input type="checkbox"/> Physical Therapy to Evaluate or Continue Therapy		
MD Signature: _____		Date: _____ Time: _____
Unit Clerk: _____	Date: _____ Time: _____	Noted by RN: _____ Date: _____ Time: _____

