

Please circle and/or check all that apply; cross out those that do not apply and fill in appropriate blanks

1. Admit to Dr. _____ dx: <input type="checkbox"/> Intracerebral Hemorrhage <input type="checkbox"/> Subarachnoid Hemorrhage	O R D E R S
2. Admit to <input type="checkbox"/> ICU <input type="checkbox"/> C4	
3. Condition: _____	
4. Activity: Bedrest, HOB elevated 30 degrees	
5. Initiate ICH Pathway Matrix	
6. Allergies/Intolerances and Manifestation: _____	
7. Code status: <input type="checkbox"/> Full Support <input type="checkbox"/> See Code Status Order Form	
8. Intake: NPO until Dysphagia Screen completed and documented <input type="checkbox"/> Dysphagia screen passed - Call MD/PA to advance diet:: Cardiac Diet <input type="checkbox"/> Dysphagia screen failed – order Speech Therapy for Swallow Evaluation and treatment	
9. Vital Signs with oximetry every 1 hour times 24 hours, 2 hours times 24 hours, and then reevaluate.	
10. Assess neurological status every 1 hour times 24 hours, 2 hours times 24 hours and then reevaluate	
11. <input type="checkbox"/> Continuous Cardiac Monitoring <input type="checkbox"/> Continuous Telemetry Monitoring for 24 hours	
12. Assess Intake and Output every shift for: _____	
13. DVT Prophylaxis: Apply SCD's (sequential compression device)	
14. Fall Risk Precaution	
15. If O ₂ started in ED, may discontinue when pulse oximetry is _____ % on room air.	
16. Physician Consults: Please check if needed: <input type="checkbox"/> Neurology for _____ <input type="checkbox"/> Neurosurgery for _____ <input type="checkbox"/> Cardiology for _____ <input type="checkbox"/> Medicine for _____	
17. Evaluations/Referrals <input type="checkbox"/> Physical Therapy evaluation and treatment put "stroke pathway" under comments <input type="checkbox"/> Occupational Therapy evaluation and treatment <input type="checkbox"/> Speech Therapy evaluation and treatment for functional communication <input type="checkbox"/> Nutritional Evaluation _____ <input type="checkbox"/> Smoking Cessation Referral _____ <input type="checkbox"/> Rehabilitation Medicine Referral _____	
18. . IV's 0.9% Sodium Chloride at 60ml per hour, discontinue after 48 hours if tolerating diet.	
19. Medications: <input type="checkbox"/> Ondansetron (Zofran) 4mg slow IV push every 6hours PRN for nausea. <input type="checkbox"/> Promethazine (Phenergan sub) 12.5mg slow IV push every 6 hours PRN for vomiting <input type="checkbox"/> Morphine Sulfate _____ mg IV every 2 hours for PRN for pain. <input type="checkbox"/> Senna 8.6mg with Docusate 50mg (Senokot-S sub) 1 tablet PO BID for constipation. <input type="checkbox"/> ACETAMINOPHEN (TYLENOL) 650mg PO/PR every 4 hours as needed for pain/fever <input type="checkbox"/> Famotidine (Pepcid) 20mg IV / PT / PO (circle choice) every 12 hours.	

Ellis Hospital *Schenectady, NY*

Form # XXXXXX (XX/XX)



ID #: XXXXXXXXXXXX

MR#: XXXXXXXXXXXX



XX X XXX DOB:

XXXXXX

Attending: XXXXXXXXXXXXXXX XXXXXXXXXXXXXXX

Blood Pressure Control Yes No

If systolic Blood Pressure is \geq 160mmHg or diastolic Blood Pressure is \geq 100mmHg for 2 or more readings 5-10 minutes apart give:

Check treatment choice: (Pharmacy will not send until requested by nursing)

IV Labetalol (Trandate) IVP 20mg IV push over 2 minutes; if not effective after 10 minutes give additional 40mg; if not effective after 10 minutes give additional 60mg; if not effective after 10 minutes give additional 80mg; if not effective after 10 minutes give additional 100mg; (maximum total dose 300mg IV); if not effective after 10 minutes contact Physician/PA. Stop Labetalol when systolic blood pressure reaches 140mmHg or per physician orders.

IV Nicardipine (Cardene) 50mg inD5W 500ml (0.1mg per ml). If peripheral line, change IV site every 12 hours. Initiate therapy at 50ml per hour (5mg per hour). Increase infusion rate by 25ml per hour (2.5mg per hour) every 15 minutes up to 150ml per hour (15mg per hour). Following achievement of the blood pressure goal (systolic 140mmHg or per physician orders), the infusion rate should be gradually reduced to maintain the desired blood pressure control. Dose should not exceed 150ml per hour.

20. **Tests:** Please check if needed: (if not done in ED)

- CT scan head, d/x Intracerebral Hemorrhage
- MRI – Brain without contrast within 24 hours – state “acute stroke protocol” in comment section
- MRA Neck Head within 24 hours state “acute stroke protocol” in comment section

Cardiovascular Services EKG

Labs

- CBC
- CMP (Comprehensive Metabolic Panel) PT, PTT

21. Other:

MD Signature: _____

Date: ____ / ____ /20 Time: _____

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