Transfer to: 10 South  
Attending Physician: 

Diagnosis: Status post TAVR  
Patient Condition: ____________________________  Code Status: Full Code

(✓) Check or fill in all orders to be implemented as appropriate.

TELEMETRY:  
✓ Transfer to telemetry bed  
☐ Telemetry may be discontinued for ordered tests/transport  
☐ Telemetry duration:  
☐ until post-operative day 4  
☐ ____________________________  

VITAL SIGNS:  
✓ Every 4 hours with neuro/circulatory checks  
✓ Monitor oxygen saturation with vital signs  
☐ Notify provider for:  
• Hypotension (systolic blood pressure less than 80 mmHg)  
• Hypertension (systolic blood pressure greater than 160 mmHg)  
• Cardiac rhythm changes/Arrhythmias/ST changes  
• Shortness of Breath  
• Neuro/Circulatory status changes  
• Chest pain  
• Bradycardia (less than 50 beats per minute)  
• Tachycardia (greater than 100 beats per minute)  
• Oxygen saturation less than 92%  
• Urine output greater than _______ mL/hour or less than _______ mL/hour  
• Any abdominal pain

DIET:  
☐ Cardiac  
☐ Diabetic: ________ calories–American Diabetic Association (ADA)

FLUID RESTRICTIONS:  
☐ ____________ mL/day

ACTIVITY:  
☐ Out of bed to chair  
☐ Ambulate with assistance three times a day  
☐ Document room air saturation with ambulation post-operative day 3

OXYGEN SUPPORT:  
☐ Oxygen by nasal cannula at ________ liters flow  
✓ Wean oxygen to saturation greater than 92%  
☐ Incentive spirometry with cough, deep breathing every hour while awake

INTRAVENOUS (IV) FLUIDS:  
☐ Peripheral IV: ____________________________________________  
☐ intermittent infusion device  
☐ ____________________________

INTAKE AND OUTPUT:  
✓ Intake and output every 8 hours. Report urine output less than 200 mL in 8 hours.  
☐ Daily weights on stand scale.  
☐ Discontinue indwelling urinary catheter  
☐ Continue indwelling urinary catheter for:  
☐ accurate intake and output  
☐ urinary retention  
☐ other (reason must be documented): ____________________________

Initials ________________
(✓) Check or fill in all orders to be implemented as appropriate.

INCISION CARE: ✓ Change groin dressing daily until discharge
☐ Chlorhexidine 2% wipes to cleanse incision with dressing changes

LABS: ☐ Complete Blood Count (CBC) and Basic Metabolic Panel (BMP) on post-operative day _________
☐ Blood glucose fingerstick before meals and at bedtime
☐ Daily Prothromin Time (PT)/International Normalized Ratio (INR) if patient on Warfarin (Coumadin)

DIAGNOSTICS:
☐ Electrocardiogram (EKG) on ________________
☐ Chest posterior and lateral x-ray on ________________ for heart disease
☐ Portable Chest X-ray on ________________ for heart disease
☐ 2 dimensional echocardiogram on post-operative day ______
☐ ________________ (indication): ____________________________

CONSULTATIONS:
✓ Physical Therapy evaluation and treatment
✓ Nutrition for diet education
✓ Discharge planning to follow

DEEP VEIN THROMBOSIS (DVT) PROPHYLAXIS (Risk Assessment on Back)
REQUIRED to (✓) check all that apply:
☐ Heparin 5000 units subcutaneous every 8 hours
☐ Enoxaparin 40 mg subcutaneous daily
☐ Enoxaparin 30 mg (if Glomerular Filtration Rate is less than 30) subcutaneous daily
☐ Pneumatic Compression Device (PCD): Knee High Pump
☐ Pneumatic Compression Device (PCD): Foot Pump
☐ Other Orders: ________________________________________
☐ DVT Prophylaxis not indicated (Reason): ______________________
☐ DVT Prophylaxis contraindicated (Reason): ______________________

EXISTING MEDICATIONS:
✓ Refer to Kaleida Transfer Profile (KTP) form for transfer medication orders (available in Powerchart).

NEW MEDICATIONS
Antidiabetic Agent: ☐ Complete “Adult Subcutaneous Insulin Orders” (KH01169)

Anticoagulation Medication
dose route interval

Beta-Blocker Medication
dose route interval indication

Angiotensin Converting Enzyme (ACE) Inhibitor Medication
dose route interval

Initials ________________

Place STAT barcode sticker within this box only on form copy being scanned
DEEP VEIN THROMBOSIS (DVT) PROPHYLAXIS RISK ASSESSMENT

RISK FACTORS

<table>
<thead>
<tr>
<th>AGE</th>
<th>points</th>
<th>IMMObILITY</th>
<th>points</th>
<th>SURGERY</th>
<th>points</th>
</tr>
</thead>
<tbody>
<tr>
<td>greater than 60 years</td>
<td>2</td>
<td>Coma</td>
<td>2</td>
<td>Hip/Pelvic/Long Bone Fracture</td>
<td>5</td>
</tr>
<tr>
<td>41 - 60 years</td>
<td>1</td>
<td>Patient confined to bed greater than 72 hours</td>
<td>2</td>
<td>Multiple Trauma</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recent uninterrupted travel greater than 4 hours</td>
<td>1</td>
<td>Major Surgery greater than 45 minute duration</td>
<td>2</td>
</tr>
</tbody>
</table>

PRE-EXISTING/CURRENT MEDICAL CONDITIONS

<table>
<thead>
<tr>
<th></th>
<th>points</th>
<th></th>
<th>points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Stroke/Paralysis</td>
<td>5</td>
<td>Current Heart Failure/ Myocardial Infarction</td>
<td>1</td>
</tr>
<tr>
<td>Previous DVT or Pulmonary Embolism (PE)</td>
<td>3</td>
<td>Obesity (greater than 20% Ideal Body Weight [IBW])</td>
<td>1</td>
</tr>
<tr>
<td>Hypercoagulation State*</td>
<td>3</td>
<td>Pregnancy/Postpartum less than 1 month</td>
<td>1</td>
</tr>
<tr>
<td>Cancer</td>
<td>2</td>
<td>Severe Dehydration</td>
<td>1</td>
</tr>
<tr>
<td>Central Venous Catheter greater than 1 week (excludes Renal Access)</td>
<td>2</td>
<td>Nephrotic syndrome</td>
<td>1</td>
</tr>
<tr>
<td>Infection (severe/sepsis)</td>
<td>1</td>
<td>Varicose Veins/Vein Surgery/Phlebitis</td>
<td>1</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)/Respiratory Distress/Steroid or Oxygen Dependent</td>
<td>1</td>
<td>Inflammatory Bowel Disease</td>
<td>1</td>
</tr>
<tr>
<td>Estrogen Use</td>
<td>1</td>
<td>Chemotherapy</td>
<td>1</td>
</tr>
<tr>
<td>(oral contraceptives, hormone replacement therapy [HRT])</td>
<td>1</td>
<td>Family Medical History unexplained DVT</td>
<td>1</td>
</tr>
</tbody>
</table>

* Examples of Hypercoagulation State: • Protein C or S deficiency • Antithrombin III deficiency • Lupus Anticoagulant • Homocysteinemia

LOW RISK (Score of 1 or less) MODERATE TO HIGH RISK* (Score of 2 - 4) HIGHEST RISK/MULTI MODAL* (Score of 5 or higher)

<table>
<thead>
<tr>
<th>No prophylaxis</th>
<th>Heparin 5000 units subcutaneous every 8 hours</th>
<th>Heparin 5000 units subcutaneous every 8 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulate</td>
<td>-OR- Pneumatic Compression Device (PCD)</td>
<td>-AND- Pneumatic Compression Device (PCD)</td>
</tr>
</tbody>
</table>

* Recommendations apply to general medical and surgical patients. Please see below for additional recommendations for specific patient populations.

ALTERNATIVE RECOMMENDATIONS FOR SPECIFIC PATIENT POPULATIONS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heparin 5000 units subcutaneous every 8 hours</td>
<td>See form KH00202 “Total Knee/ Hip Arthroplasty Post-Operative Orders”</td>
<td>Enoxaparin 30 mg subcutaneous every 12 hours</td>
<td>Enoxaparin 40 mg subcutaneous daily (Enoxaparin 30 mg subcutaneous daily if Creatinine Clearance [CrCl] less than 30 mL/minute)</td>
<td>Enoxaparin 40 mg subcutaneous every 12 hours</td>
<td>Pneumatic Compression Device (PCD)</td>
<td>Fondaparinux 2.5 mg subcutaneous daily (Contraindicated if Creatinine Clearance [CrCl] less than 30 mL/minute)</td>
</tr>
</tbody>
</table>

Consider platelet monitoring for prolonged anticoagulation

References:

ORDERS
IMMUNIZATIONS

Per New York State Department of Health Mandatory Immunization Program and Kaleida Policy CL.6:

- **All patients 6 to 64 years old with chronic health conditions and all patients age 65 or older** admitted to Kaleida will be screened to determine eligibility for the pneumococcal immunization and all eligible patients will be offered the vaccine.

- All patients admitted to Kaleida age **6 months and older** will be screened to determine eligibility for influenza immunization and all eligible patients will be offered the vaccine.

The immunization(s) will be held if the patient has a contraindication. Please select the appropriate contraindication(s) and sign the *Adult Pneumococcal/Influenza Vaccination Screening & Orders* (KH01183) to have the immunization(s) held.

ADDITIONAL MEDICATIONS

<table>
<thead>
<tr>
<th></th>
<th>dose</th>
<th>route</th>
<th>interval</th>
<th>indication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ADDITIONAL ORDERS

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

TORB = Telephone Orders Read Back