



Height:	Weight:	PHYSICIANS ORDERS ADULT DELIRIUM
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**THIS ORDER SET NOT APPROPRIATE FOR USE IN PATIENTS WITH:
 Alcohol withdrawal
 Malignant Hyperthermia or Neuroleptic Malignant Syndrome**

Recommended for all patients with delirium:

- Vital Signs with transcutaneous oxygen saturation STAT
- Repeat Vital Signs every _____ hours
- Arterial Blood Gas STAT
- Capillary Blood Glucose (Accucheck) STAT
- Repeat Capillary Blood Glucose every _____ hours
- Basic Metabolic Panel _____ Routine _____ STAT
- 12-lead Electrocardiogram _____ Routine _____ STAT
(re: altered mental status)
- Complete Blood Count _____ Routine _____ STAT

To be considered for all patients with delirium, as indicated:

- Comprehensive Metabolic Panel _____ Routine _____ STAT
- Ionized calcium _____ Routine _____ STAT
- Magnesium _____ Routine _____ STAT
- Urinalysis with microscopy _____ Routine _____ STAT
- Urine culture and sensitivity _____ Routine _____ STAT
- Blood cultures x 2 sets _____ Routine _____ STAT
- Chest Xray: **PA/LAT** _____ Routine _____ STAT
(re: altered mental status)
- Chest Xray: **Portable** _____ Routine _____ STAT
(re: altered mental status)
- Other: _____

- IVF Saline lock Other: _____
- Consult clinical pharmacist (call 655-2285) (re: review medication list for potential contributors to delirium)
- Haloperidol (**oral route preferred if possible**)
 Haloperidol PO
 - 0.5 mg PO STAT x 1 then
 - 0.5 to 1mg PO, every 4 hours PRN agitation (do not exceed 3 mg total per 24 hours)**OR**
 Haloperidol IM
 - 0.5 to 1mg IM STAT x 1 then
 - 0.5 to 1 mg IM, every 4 hours PRN agitation (do not exceed 3 mg total per 24 hours)

Physician Signature:	Dictation #:
Date/Time:	



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Additional Nursing

- Determine with patient / family whether patient uses eyeglasses or hearing aids. If yes, please facilitate patient's constant use of these during non sleeping hours.
- Patient room should have a wall clock easily visible by patient
- Keep patient room quiet and dimly lit during usual sleeping hours and brightly lit during waking hours
- Other: _____

Physician Signature

Date

Physician Signature:

Dictation #:

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