



**PHYSICIAN ORDER SET**

AUTHORIZATION IS GIVEN TO THE PHARMACY TO DISPENSE AND TO THE NURSE TO ADMINISTER THE GENERIC OR CHEMICAL EQUIVALENT WHEN THE DRUG IS FILLED BY THE PHARMACY OF THE UPMC HEALTH SYSTEM HOSPITAL - UNLESS THE PRODUCT NAME IS CIRCLED.

IMPRINT PATIENT IDENTIFICATION HERE

**Continuous Subcutaneous Insulin Pump Orders**

Attending Physician: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_

*Check All Orders that Apply with a  & All Handwritten Orders Should be **BLOCK PRINTED** for Clarity*

**Discontinue all Previous Insulin Orders**

Patient to self administer insulin via subcutaneous insulin pump and document all basal rates and boluses on the "Insulin Pump Log Sheet". Nurse to review and verify that patient is documenting on the "Insulin Pump Log Sheet" every shift.

Patient to continue home basal rates and bolus doses as per "Assessment Sheet for Insulin Pump Patients" unless indicated below.

Patient to change insertion set/site every 48-72 hours and as needed.

**Check capillary blood glucose:**

QAC and QHS  QAC  Q6hours  Q4hours  3am  Other: \_\_\_\_\_

Initiate Hypoglycemia Treatment Protocol for any blood glucose < 70 mg/dl - do not remove/stop pump unless ordered by physician

If blood glucose > 250 mg/dL two times in a row, patient to change infusion set and nurse to notify physician

**HbA1c** (recommended to assess home pump self-management)

**If the pump is discontinued for any reason, contact physician for further orders for insulin management. Do not stop the pump without prescriber order and plans for alternate insulin administration.**

**Insulin (for use in pump):** Pharmacy to send vial so patient can fill the cartridge.

lispro (**HumaLOG**)  aspart (**NovoLOG**)  glulisine (**Apidra**)  Regular

**Diet:**  Diabetic Consistent Carbohydrate Diet

Other diet: \_\_\_\_\_

**Consults:**  Diabetes Service (pager **1082**) for pump management (recommended)

Nutrition Consult for: \_\_\_\_\_

**Additional Orders Should be BLOCK PRINTED for Clarity**

The following abbreviations are disallowed: u (unit), MS and MSO4 (morphine), MgSO4 (magnesium sulfate), QD (daily), QOD (every other day), IU (International Units)

**Other Orders**

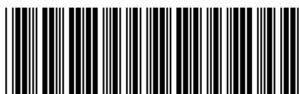
**Medication Orders**

Safe Prescribing Practices: Verify all orders by reading the order back to the prescriber. Do not use zeros following a decimal point. Use a zero before a decimal point. Order IV medications by dose per time (e.g., mg/hr). Order levothyroxine in "mcg" (not "mg") doses.

(**BLOCK** Print Name)

(Signature)

Date / Time: \_\_\_\_\_ Pager # \_\_\_\_\_



**Order Set Faxed to Pharmacy by:**  
(name / time)

**Unit:** \_\_\_\_\_



# Assessment Sheet for Insulin Pump Patients



9384-01-U

IMPRINT PATIENT IDENTIFICATION HERE

Patient Name: \_\_\_\_\_

### Pump information:

- Pump model and manufacturer? \_\_\_\_\_
- Pump customer support number? \_\_\_\_\_
- Type of insulin used in pump? \_\_\_\_\_
- Type of infusion set used? Do you use an inserter? \_\_\_\_\_

Do you have insulin pump supplies with you? \*  YES  NO If Yes, how many days supply do you have? \_\_\_\_\_  
*\*You must provide your own pump supplies except for insulin*

Is there an emergency person who can help you with pump use?  YES  NO

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

### Current basal rates:

Start time	End time	Basal rate units/hour
12am	1am	
1am	2am	
2am	3am	
3am	4am	
4am	5am	
5am	6am	
6am	7am	
7am	8am	

Start time	End time	Basal rate units/hour
8am	9am	
9am	10am	
10am	11am	
11am	12pm	
12pm	1pm	
1pm	2pm	
2pm	3pm	
3pm	4pm	

Start time	End time	Basal rate units/hour
4pm	5pm	
5pm	6pm	
6pm	7pm	
7pm	8pm	
8pm	9pm	
9pm	10pm	
10pm	11pm	
11pm	12am	

### Meal boluses:

Based on carbohydrate count:

OR

Fixed doses:

Breakfast : \_\_\_\_\_ units per \_\_\_\_\_ grams carbohydrate  
 Lunch: \_\_\_\_\_ units per \_\_\_\_\_ grams carbohydrate  
 Supper: \_\_\_\_\_ units per \_\_\_\_\_ grams carbohydrate  
 Snacks: \_\_\_\_\_ units per \_\_\_\_\_ grams carbohydrate

\_\_\_\_\_ units at breakfast  
 \_\_\_\_\_ units at lunch  
 \_\_\_\_\_ units at supper  
 \_\_\_\_\_ units with snacks

### Correction boluses:

\_\_\_\_\_ unit(s) for every \_\_\_\_\_ mg/dl over \_\_\_\_\_ mg/dl (target glucose)

(for high blood glucoses)

OR One unit of insulin brings my glucose down: \_\_\_\_\_ mg/dl

OR provide copy of written scale

**\*Please provide a demonstration of the pump including current basal rates and meal/correction bolus delivery.**

Staff member(s) reviewing form and witnessing patient demonstration:

(Print name/Signature) \_\_\_\_\_

Date / Time: \_\_\_\_\_

(Print name/Signature) \_\_\_\_\_

Date / Time: \_\_\_\_\_

# INSULIN PUMP LOG SHEET



9625-01-U

IMPRINT PATIENT IDENTIFICATION HERE

Date:	12M	6AM	7AM	8AM	9AM	10AM	11AM	12N	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM	
Insulin Type																				
Glucose																				
CHO (grams)																				
Meal bolus																				
Correction bolus																				
Basal rate																				
Site change (Indicate location)																				

RN signature:

Date:	12M	6AM	7AM	8AM	9AM	10AM	11AM	12N	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM	
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