**SUBARACHNOID HEMORRHAGE SUPPLEMENTAL ORDER SET**

<table>
<thead>
<tr>
<th>Admission Status:</th>
<th>☐ Inpatient  ☐ Observation  ☐ Adult ICU  ☐ Progressive Care/Telemetry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis:</td>
<td>☐ Intracerebral Hemorrhage  ☐ Other: ________________________________</td>
</tr>
<tr>
<td>Allergies:</td>
<td>☐ NKDA  ☐ Other: ____________________________</td>
</tr>
<tr>
<td>Weight:</td>
<td>___________________________ kg</td>
</tr>
<tr>
<td>Courtesy notification of PCP (if applicable):</td>
<td>____________________________</td>
</tr>
<tr>
<td>Admitting Physician:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Consulting Physician:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Code Status:</td>
<td>☐ Full Code  ☐ DNR  ☐ Other: ____________________________</td>
</tr>
</tbody>
</table>

**Denotes Joint Commission/Clinical Practice Guideline**

**HUNT & HESS CLASSIFICATION SCORE:**

- **Grade I**  Asymptomatic, mild headache, slight nuchal rigidity
- **Grade II**  Moderate to severe headache, nuchal rigidity, no neurological deficit other than cranial nerve palsy
- **Grade III**  Drowsiness, confusion, mild focal neurological deficit
- **Grade IV**  Stupor, moderate to severe hemiparesis
- **Grade V**  Coma, decerebrate posturing

**DIAGNOSTIC WORKUP:** (if not completed in ED)

- ☐ CBC  ☐ CMP
- ☐ "Lipid Panel" in AM  ☐ PT/PTT/INR
- ☐ ESR  ☐ RPR
- ☐ "HGB A1C"  ☐ UA
- ☐ UDS  ☐ EKG
- ☐ CTA/CTP (If not done in ED)
- ☐ MRI Head  ☐ with &/or  ☐ w/o contrast
- ☐ TCD DAILY STARTING ___________________________ DATE
- ☐ Other: ____________________________
- ☐ Other: ____________________________
- ☐ Other: ____________________________

**ACTIVITY:**

- ☐ Bedrest with HOB elevated 30°  ☐ OOB with assist  ☐ Bathroom privileges

**THERAPY/TREATMENTS:**

- ☐ Vital signs with Neuro checks:  ☐ ICU - (write in time/frequency): ____________________________
- ☐ 4A - (write in time/frequency): ____________________________
- ☐ "NIH Stroke Scale": on admission to unit, then modified scale (item #s 1,5,6) every shift.
- For the intubated, sedated patient, complete Glasgow Coma Scale and pupil assessment at the above chosen interval in place of NIHSS.
- Call physician for changes in LOC or Neuro Exam.
- ☐ Strict I&O with daily weight
- ☐ Place nasogastric tube
- ☐ PRECAUTIONS: No bright lights or loud noises, including TV or radios.

**NUTRITION:**

- ☐ NPO  ☐ Other: ____________________________
**DIAGNOSIS:**

**PHYSICIAN ORDERS**

**DRUG SENSITIVITY:**

**SUBARACHNOID HEMORRHAGE SUPPLEMENTAL ORDER SET**

**Nurse to complete Nursing dysphagia screen (Swallow Screening) prior to anything PO, including medications.**

NPO - Until nursing performs dysphagia screening (swallow screening). IF abnormal, keep patient NPO and consult Speech Therapy urgently. IF normal, then give 1800 Kcal ADA diet, no concentrated sweets

**CONSULTS:**  
**Assessed for rehabilitation**

- PT  
- OT  
- PT  
- Inpatient Rehabilitation Evaluation  
- Neurosurgery  
- Other: ____________________________

**DVT PROPHYLAXIS:**

- TEDS/SCDS  
- Other: ____________________________

**PATIENT EDUCATION:**  
Stroke education & smoking cessation teaching

- IVF: ____________________________ at ____________________________ ml/hour ____________________ Saline Lock

GOAL blood pressure range: SBP _____ to SBP _____  
DBP _____ to DBP _____

**MEDICATIONS:** NPO (including medications until bedside swallow evaluation complete).

- Labetalol ________ mg slow IVP every 10 min PRN to a maximum of ________ mg/day
- Labetalol 0.5 mg/min IVPB, titrate 0.5 mg/min every 30 minutes to a maximum dose of 2 mg/min
- Nicardipine 5 mg/hour IVPB, titrate by 2.5 mg/hour every 15 min to a maximum dose of 15 mg/hour.

**When goal blood pressure reached, decrease by 3 mg/hour**

**Monitor blood pressure every 5 min while on IV Labetalol infusion and 5 min after each IV injection**

- Other: ____________________________

**ADDITIONAL ORDERS/MEDICATIONS:**

- See Medication Reconciliation Form
- See transfer MAR

Titrated drips, other than Nitroglycerin and Heparin, should be administered in ICU only.

Date: ___________ / _________ / _________  
Time: ___________

Physician Name (Print)  
Pager  
Physician Signature

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