Osler Standard Order Set

<table>
<thead>
<tr>
<th>WEIGHT:</th>
<th>kg</th>
<th>HEIGHT:</th>
<th>cm</th>
</tr>
</thead>
</table>

ESTIMATED DATE OF DISCHARGE:

ALLERGIES: ☐ NO KNOWN ALLERGIES

---

### Insulin Orders for Patients with Type 2 Diabetes Order Set

Fill in required blanks and check appropriate boxes. To delete order, draw line through and initial. Orders not checked will not be implemented.

☐ Discontinue all Previous Insulin Orders and Oral Hypoglycemics (See reverse for list)
☐ Except for: ____________________________________________

**Monitoring**

☐ Blood Glucose Meter:

- TID ac
- TID ac + QHS
- q4h
- BID
- 0300 hrs
- Other: ______________________

### Scheduled Insulin

☐ No Basal Insulin Order OR
☐ Basal Insulin (select one):

- Insulin Humulin N ☐ _______ units subcutaneously ☐ _______________ (frequency)
- Insulin Novolin NPH ☐ _______ units subcutaneously ☐ _______________ (frequency)
- Insulin Glargine ☐ _______ units subcutaneously ☐ _______________ (frequency)

☐ No Pre-Mixed Insulin Orders OR
☐ Premixed insulin (select one):

- Insulin Novolin 30/70® OR ☐ Insulin Humulin 30/70®
  - Administer premixed insulin ☐ _______ units subcutaneously prior to breakfast
  - Administer premixed insulin ☐ _______ units subcutaneously prior to dinner

☐ No Mealtime Insulin Orders OR
☐ Mealtime insulin (select one):

- Insulin Aspart (NovoRapid®) OR ☐ Insulin Lispro (Humalog®) OR ☐ Insulin Humulin R OR
- Insulin Novolin ge Toronto
  - Administer mealtime insulin ☐ _______ units subcutaneously prior to breakfast
  - Administer mealtime insulin ☐ _______ units subcutaneously prior to lunch
  - Administer mealtime insulin ☐ _______ units subcutaneously prior to dinner

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Prescriber Signature and Mnemonic

Date/Time

Transcribed By

Date/Time

Checked By

Date/Time

Form #: 10 100 XXX V.1.1

XXX

Rx Code #
**Osler Standard Order Set**

**WEIGHT:** kg  
**HEIGHT:** cm

**ESTIMATED DATE OF DISCHARGE:**

**ALLERGIES:** ☐ NO KNOWN ALLERGIES

---

### Insulin Orders for Patients with Type 2 Diabetes Order Set

Fill in required blanks and check appropriate boxes. To delete order, draw line through and initial. Orders not checked will not be implemented.

**Correctional Subcutaneous Sliding Scale Insulin**

**Correctional subcutaneous insulin (Select One):**

☐ Insulin Aspart (NovoRapid®)  OR  ☐ Insulin Lispro (Humalog®)  OR  ☐ Insulin Humulin R  OR

☐ Insulin Novolin ge Toronto

☒ Correctional subcutaneous insulin to be administered in addition to mealtime insulin orders (if ordered)

**Correctional Subcutaneous Sliding Scale Insulin to be administered (Indicate Frequency):**

Coverage:  ☐ Every time before meals  ☐ q4h  ☐ None  ☐ Other: _______________

<table>
<thead>
<tr>
<th>Scale (Select one)</th>
<th>Low Dose</th>
<th>Moderate Dose</th>
<th>Patient-Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 4 mmol/L</td>
<td>Hypoglycemia protocol</td>
<td>0 units</td>
<td>0 units</td>
</tr>
<tr>
<td>4.1 – 9.9 mmol/L</td>
<td></td>
<td>2 units</td>
<td>4 units</td>
</tr>
<tr>
<td>10.0 – 13 mmol/L</td>
<td></td>
<td>3 units</td>
<td>5 units</td>
</tr>
<tr>
<td>13.1 – 17 mmol/L</td>
<td></td>
<td>4 units</td>
<td>8 units</td>
</tr>
<tr>
<td>Greater than 20 mmol/L</td>
<td>Notify Physician</td>
<td>6 units and Notify Physician</td>
<td></td>
</tr>
</tbody>
</table>

☒ To be used in conjunction with Hypoglycemia Protocol
☐ Do not administer correctional subcutaneous sliding scale insulin at bedtime
☐ Administer one-half dose correctional subcutaneous insulin at bedtime as per sliding scale and document in Medication Administration Record (MAR)
☐ Refer to Diabetes Education Clinic for insulin education upon discharge

☒ Notify MRP or Endocrinologist (if Endocrinologist involved) if
  - Patient becomes NPO
  - Oral diet initiated from NPO status
  - Oral diet advances from fluids to solids
  - Tube feeds held/stopped due to a test(s) or change in medical condition
  - Reduction with tube feed rate due to intolerance or other acute medical condition

**THEN**

Physician to reassess Patient Blood Glucose **within 48 hours** and rewrite **new insulin orders if required**

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**Prescriber Signature and Mnemonic**

_________________________  Page 2 of 3  ______________________________

**Date/Time**

_________________________  ______________________________

**Transcribed By**

_________________________  **Date/Time**

**Checked By**

_________________________  **Date/Time**

**Form #: 10 100 XXX V.1.1**

**XXX**  

**Rx Code #:**