MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
600 University Avenue
Toronto, Ontario, Canada M5G 1X5

PRE-PRINTED ORDER RECORD

Clearly imprint patient identification card

Allergies *(also specify reaction)* ☐ None known

Date (YYYY MM DD)

Write firmly for legible copy

Emergency Department
Symptoms Suggestive of Hip Fracture

Form D648 (Rev. 09.2011)

Item	Order	Transcribed
1	**Clinical Assessment** Patient presents with symptoms suggestive of hip fracture: • Pain in the hip, groin and/or knee • Severe pain with movement of affected limb **Assess verbal and non-verbal pain cues** • External rotation and/or shortening of affected limb • Inability to weight bear on affected side	
2	**Clinical Diagnostics** ☐ CBC, Electrolytes, Urea, Creatinine, Blood glucose, PT, INR, Group and Screen ☐ ECG ☐ X-ray of affected hip: ☐ Right hip ☐ Left Hip ☐ X-ray – Other _____ ☐ Additional Diagnostics: _____	
3	**Clinical Interventions** ☐ Keep patient NPO ☐ Initiate IV therapy with 0.9% normal saline. Bolus _____ mL over _____ minutes. ☐ Initiate IV therapy with 0.9% normal saline @ _____ mL/hr ☐ Insert urinary catheter to straight drain for female patient	
4	**Clinical Monitoring** • Document temperature, heart rate, respiratory rate, oxygen saturation, blood pressure and pain scale prior to and 30 min to 1 hour after administration of analgesia • ED MD to consider use of Iliofascial 3 in 1 block to reduce the need for systemic analgesic. Monitor effect of Iliofascial block • Document neurovascular status of affected limb (using 5P's: pain, pulses, pallor, paresthesia, paralysis) Q4H • Document ISAR score if patient >65 years	
5	**Medications** **For patients with known Dementia, consider beginning with* HYDROmorphone (Dilaudid) 0.5mg IV ☐ HYDROmorphone (Dilaudid) 0.5 -1mg IV Q1hour PRN until pain relieved. If pt requires 4mg in 4 hours, please contact MD to reassess. ☐ Ondansetron 4mg IV Q8H PRN for nausea and vomiting Other _____	
6	**Consults** ☐ Orthopedics ☐ Anesthesia ☐ General Medicine ☐ Geriatrics ☐ Social Work ☐ Pharmacy	

Date	Time	Print Name	Signatures
(YYYY MM DD)	(HH : MM)		, M.D.
(YYYY MM DD)	(HH : MM)		, R.N.

Reviewed by

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