

CCU-3375-FRM
REV 2 02.23.23

Conway Medical Center
Conway, South Carolina
PHYSICIAN'S ORDERS

Dexmedetomidine (Precedex®) Infusion

Order Form
(ICU/PCU Only)

Center Patient Admission
Label Here

Drug Allergies:

Patient Weight: _____ kg

Use with caution in patients with: heart block, severe ventricular dysfunction, hypovolemia.

Indications for Use of Dexmedetomidine (Precedex)

1. Patient requiring sedation that has "failed" traditional therapy
2. Mechanically ventilated, CPAP/BiPaP, Hi-Flo patient requiring a temporary (<24hrs) sedative where minimal respiratory depression and/or short half-life would be of benefit.

Preparation: 4 mcg/ml

Physician Orders:

*** Order will automatically discontinue in 24 hrs. Physician will evaluate daily the need for extended use.**

- ☒ Record baseline vital signs and MAP.
- ☐ Reduce propofol / midazolam infusion rate by ½ when dexmedetomidine started. Wean sedative to off as dexmedetomidine is titrated up.
- ☐ Dexmedetomidine loading dose: 1 mcg/kg IV dexmedetomidine bolus infused over 10 minutes.
- ☒ Dexmedetomidine maintenance infusion: Start infusion at rate of **0.2 mcg/kg/hr**. Titrate to effect in increments of 0.1 mcg/kg/hr every 20 minutes (max dose: 0.7 mcg/kg/hour).
 - Monitor BP and heart rate q 5 min until BP stable for every change in infusion rate
- ☒ Titrate to Modified Ramsay Scale of _____
 - Modified Ramsay Scale
 1. Patient anxious, agitated, or restless
 2. Patient cooperative, oriented and tranquil
 3. Patient responds to commands only
 4. Patient responds to gentle shaking
 5. Patient responds to noxious stimulus
 6. Patient has no response to firm nail bed pressure or other noxious stimuli
- ☒ Decrease infusion rate by half and notify physician for MAP 70 - 75 mmHg.
- ☒ Hold infusion and notify physician for MAP less than 70 mmHg.
- ☒ Decrease infusion rate by half and notify physician for heart rate 45 - 50 beats/min.
- ☒ Hold infusion and notify physician for heart rate less than 45 beats/min.

(Atropine or glycopyrrolate may be effective in treating side effects by modifying vagal tone.)

*****Notify Physician if goal not met at max dose*****

Physician Signature

_____/_____/_____
Date

Time

Nurse #1 Signature

_____/_____/_____
Date

Time

Nurse #2 Signature

_____/_____/_____
Date

Time

DO NOT WRITE IN THIS AREA