



PHYSICIAN'S ORDERS

ALLERGIES: See Master Allergy Sheet

| ORDERED | | POST OPERATIVE ORDERS | TIME ORDER NOTED |
|---------|------|---|---------------------|
| Date | Time | | |
| | | <p><i>Check Appropriate Boxes:</i></p> <p>To floor when vital signs stable.</p> <p>Status post op for:</p> <p>Condition:</p> <p><input type="checkbox"/> Consult: _____ for the following conditions:</p> <p>Diet: Clear Liquids post nausea, advance to regular as tolerated.</p> <p>Bed rest until following morning, then activity ad lib.</p> <p>Vital signs every 4 hours X 6 times, then four times daily.</p> <p>IV D5LR 125 ml per hour.</p> <p>Ceftriaxone Sodium (Rocephin) 1 gm IVPB tomorrow AM.</p> <p>Hematocrit 6 p.m. day of surgery and 6 a.m. following morning, and call physician if less than 30 (thirty).</p> <p>Simethicone (Mylicon) 80 mg one (1) by mouth four times daily.</p> <p>Bisacodyl (Dulcolax) suppository one (1) per rectum as needed for gas pains.</p> <p>Abdominal binder if desires.</p> <p>Heating pad to Bedside, use on abdominal incision as desires.</p> <p>Incentive spirometry every 3 hours while awake for 48 hours.</p> <p>Meperidine (Demerol) 75 mg & Promethazine (Phenergan) 50 mg IM every 3 hours as needed for severe pain.</p> <p>Propoxyphene Napsulate (Darvocet-N 100) (1) by mouth every 4 hours as needed for less severe pain, or Hydrocodone with Acetaminophen (Lortab 7.5) (1) by mouth every 3 hours as needed for less severe pain.</p> <p>Docusate (Colace) 100-mg (1) by mouth every day.</p> <p>Foley to bedside drainage.</p> <p>Chloraseptic spray to bedside, use as needed for sore throat.</p> <p>PCA</p> <p>Promethazine (Phenergan) 25 mg IV every 6 hours – hold for sedation.</p> <p>DVT Prophylaxis:</p> <p><input type="checkbox"/> SCD hose to legs in PACU PLUS</p> <p><input type="checkbox"/> Warfarin (Coumadin) _____ mg every day PO, hold if PT > 15.9 OR</p> <p><input type="checkbox"/> Enoxaparin (Lovenox) 30 mg SQ every 12 hours daily OR</p> <p><input type="checkbox"/> Fondaparinux (Arixtra) 2.5 mg SQ daily</p> <p><input type="checkbox"/> Anticoagulation Contraindications:</p> <p><input type="checkbox"/> Bleeding risk</p> <p><input type="checkbox"/> Other documented reason:</p> <p>Physician Signature: _____ Date/Time: _____</p> | |

▼ Patient Label ▼

