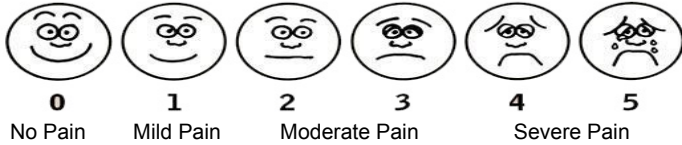


Room #: _____ Patient Weight: _____ kg

Patient's Allergies & Type of Reaction (nursing to verify)

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PAIN SCALE



WARNING: DO NOT USE ABBREVIATIONS

- U,u
- IU
- Q.D, QD,q.d,qd
- Q.O.D,QOD,q.o.d.,qod
- Trailing zero (X.0mg)
- Lack of leading zero (.Xmg)
- Any medication

ADULT ORDER SHEET

ALL OTHER ORDERS

Date _____ Time _____

Assign to: _____ MD

MEDICATIONS

Admission Diagnosis:

Status Post Procedure:

Pertinent Medical History: (for maintenance meds & nursing care)

Allergies & Reactions:

Condition:

Vital Signs per floor routine Other

Nursing:

Diet Advance as tolerated Reg Soft Clear Other

Head Position ↑45° Prone Other _____

Pneumatic compression boots until ambulatory

Activity as tolerated Other _____

Observe for:

- GI distress
- Bleeding
- Other
- Respiratory distress
- Blind precautions

IVF D5½ NS @ _____ ml/hour

Other _____ @ _____ ml/hr

Additives: KCl @ 20 mEq/L KCl @ 40 mEq/L
 Other

WARNING: When using additives, order appropriate laboratory tests

Discontinue IV when tolerating PO/PT fluids & saline lock IV

Acetaminophen 650mg PO/PT Q 4 hours PRN mild pain
WARNING: DO NOT EXCEED 4 grams/24 hours

Roxicet is Percocet Equivalent:
Liquid Each 5 ml = Oxycodone 5mg/Acetaminophen 325 mg

Roxicet 5mg/325 mg -5ml PO/PT q 4° PRN moderate pain

Roxicet Roxicet 5 mg/325mg -10ml PO/PT q 4° PRN severe pain

Tablet Each 5ml = Oxycodone 5mg/Acetaminophen 325 mg

Roxicet 5mg/325 mg -1 tablet PO q 4° PRN moderate pain

Roxicet 5mg/325 mg -2 tablets PO q 4° PRN severe pain

WARNING: DO NOT EXCEED 4 grams of Acetaminophen per 24 hours

If severe pain not relieved use morphine sulfate

Morphine Sulfate 2 mg subQ q 4° PRN severe pain.
May repeat 2 mg subQ in 15 minutes

Ondansetron 4mg IV PRN nausea or vomiting x 1 if not given in OR. If patient continues nausea or vomiting use promethazine

Promethazine 25mg PO/PT Q6 hours PRN nausea

Promethazine 25mg IM Q6 hours PRN nausea

Antibiotics:

Additional Orders on separate order sheet

Discharge patient home when meets criteria with Instructions, prescriptions and return office information

Responsible physician(s) for additional issues:

- Resident _____ MD
- Fellow _____ MD
- Attending _____ MD

Date: _____ Time: _____

Ordering MD Signature: _____

Ordering MD Printed Name: _____

Ordering MD Beeper/Phone#: _____

DO NOT WRITE IN THIS SPACE

ADULT ORDERS SHEET