

PHYSICIAN'S ORDERS



CULLMAN
REGIONAL

NAME:
ROOM NO:
(ADDRESS)
HOSP. NO.
PHYSICIAN

Another brand of drug identical in form and content may be dispensed unless checked. <input type="checkbox"/>	
Dr. Dueland & Dr. Gomez - Admission Order Set (page 1 of 2)	
Admit to: <input type="checkbox"/> 5 East <input type="checkbox"/> CCU	
Admission type: <input type="checkbox"/> Admit Inpatient <input type="checkbox"/> Outpatient	
Diagnosis: _____	
Consent: _____	
Condition: <input type="checkbox"/> Stable <input type="checkbox"/> Guarded <input type="checkbox"/> Critical	
Allergies: _____	
Vital Signs: <input type="checkbox"/> q 4 hours <input type="checkbox"/> q 4 hours (while awake) <input type="checkbox"/> Routine	
Diet: <input type="checkbox"/> NPO after _____ <input type="checkbox"/> Regular <input type="checkbox"/> Consistent Carb <input type="checkbox"/> Cardiac	
IV: <input type="checkbox"/> D5 1/2 NS @ _____ cc/hr <input type="checkbox"/> LR @ _____ cc/hr <input type="checkbox"/> D5 NS @ _____ cc/hr <input type="checkbox"/> Saline Lock	
Activity: <input type="checkbox"/> Bed Rest <input type="checkbox"/> Bed Rest with BRP <input type="checkbox"/> Up ad lib <input type="checkbox"/> OOB for meals	
Nursing: <ul style="list-style-type: none"> • Begin Incentive Spirometry Protocol, notify Respiratory Therapy • Turn, cough, deep breath q 2 hours x 48 hours while awake <input type="checkbox"/> Neuro checks: <input type="checkbox"/> q 2 hours <input type="checkbox"/> q 4 hours <input type="checkbox"/> Ice pack to affected area q 2 hours on/2 hours off <input type="checkbox"/> Elevate affected extremity above the level of the heart <input type="checkbox"/> Ace wrap to affected area: <input type="checkbox"/> 2 inch <input type="checkbox"/> 3 inch <input type="checkbox"/> 4 inch <input type="checkbox"/> 6 inch <input type="checkbox"/> Routine cast care <input type="checkbox"/> Bilateral intermittent compression device <input type="checkbox"/> TED hose: <input type="checkbox"/> Knee high <input type="checkbox"/> Thigh high <input type="checkbox"/> Decubitus precautions <input type="checkbox"/> Empty and record drain output q 8 hours <input type="checkbox"/> Foley catheter <input type="checkbox"/> Straight cath PRN urinary retention <input type="checkbox"/> DC foley catheter: <input type="checkbox"/> POD 1 <input type="checkbox"/> POD 2 	
Physical Therapy: <input type="checkbox"/> Right UE <input type="checkbox"/> Left UE <input type="checkbox"/> Right LE <input type="checkbox"/> Left LE <input type="checkbox"/> No use <input type="checkbox"/> Passive ROM only <input type="checkbox"/> Toe touch only <input type="checkbox"/> Partial WBAT <input type="checkbox"/> Full WBAT <input type="checkbox"/> Other: _____ <input type="checkbox"/> Ambulation/Gait Training <input type="checkbox"/> Strengthening <input type="checkbox"/> Sling to affected extremity <input type="checkbox"/> Sling and swathe to affected extremity <input type="checkbox"/> Shoulder immobilizer: <input type="checkbox"/> Full time except for PTx <input type="checkbox"/> Do Not Remove <input type="checkbox"/> Recon Brace affected extremity: <input type="checkbox"/> Full time except for PTx <input type="checkbox"/> Do Not Remove <input type="checkbox"/> Lock for ambulation <input type="checkbox"/> Drop lock to _____ degrees for sitting	
MD Signature: _____ Date & Time _____	

Cullman Regional

Please use Ball Point Pen ONLY

Physician's Orders

DO NOT USE: U IU QD QOD MS MSO4 MgSO4



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REGIONAL

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Dr. Dueland & Dr. Gomez - Admission Order Set

(page 2 of 2)

Physical Therapy: ☐ CPM 4 hours on/4 hours off ROM: _____
(continued) ☐ Daily whirlpool with dressing changes
☐ Buck's tx 5#

Meds:

Pain Management Orders:

For mild pain (scale 1-3)

☐ Tylenol 650 mg Po q 6 hr PRN pain/fever

For moderate pain (scale 4-7)

☐ Norco 5/325 1 tab Po q 6 hr PRN

☐ Toradol 30 mg IV q 8 hr PRN

☐ Dilaudid 1 mg IV q 2 hr PRN

☐ Dilaudid 1 mg IV q 4 hr PRN

☐ Morphine 2 mg IV q 2 hr PRN

☐ Morphine 2 mg IV q 4 hr PRN

☐ Zofran 8 mg Po q 6-8 hours PRN nausea if no IV

☐ Zofran 4 mg IV q 6 hours PRN nausea

☐ Antibiotics: _____

☐ Home Medications: _____

Pain Management Orders:

For severe pain (scale 8-10)

☐ Dilaudid 2 mg IV q 2 hr PRN

☐ Dilaudid 2 mg IV q 4 hr PRN

☐ Morphine 4 mg IV q 2 hr PRN

☐ Morphine 4 mg IV q 4 hr PRN

Other Pain Management Medications:

☐ _____

Labs: ☐ CBC with manual Diff ☐ BMP ☐ CMP
☐ Sedimentation Rate ☐ CRP ☐ UA
☐ Blood Culture x 2 (collect prior to antibiotics)
☐ Wound Culture: _____ (collect prior to antibiotics)
☐ Other: _____

Xrays: ☐ CXR
☐ CT Scan: _____ R/O: _____
☐ MRI: _____ R/O: _____
☐ Tagged White Cell Study
☐ Limited bone scan: ☐ Lower Extremities ☐ Upper Extremities R/O: _____
☐ Post-void Total Body Bone Scan R/O: _____

Consults: ☐ Hospitalist Service for medical management/surgical clearance
☐ Primary MD: _____ medical management/surgical clearance
☐ Case Management for discharge planning ☐ Physical Therapy ☐ Dietitian for nutrition

May use Standing Orders.

MD Signature: _____ **Date & Time** _____

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DO NOT USE: U IU QD QOD MS MSO4 MgSO4