



**CULLMAN**  
REGIONAL

## PHYSICIAN'S ORDERS

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

Med(s) causing Anaphylactic Reaction: \_\_\_\_\_

**Another brand of drug identical in form and content may be dispensed unless checked. ☐**

### **High Dose Protocol for Induction In 2<sup>nd</sup> Trimester Fetal Demise 28 Weeks or Less Pitocin Order Set**

Admit inpatient per \_\_\_\_\_

1. **Diet:** NPO except ice chips and medications

2. **Labs:** ☐ CBC no Diff    ☐ CBC with auto Diff    ☐ CBC with manual Diff  
Basic Metabolic Panel  
RPR  
Type/Screen  
UA Dip maternity

3. **IV Fluids:** Start IV with #18 gauge cathlon to infuse D5NS at KVO.

4. **Meds:** Notify Pharmacy that protocol is being implemented.

- a. Oxytocin 50 units in 500 ml D5NS to infuse over 3 hours per infusion pump.
- b. DC Oxytocin for 1 hour. D5NS at 125 ml/hr for 1 hour. Call Pharmacy to inform them when next bag is to be initiated.
- c. Oxytocin 100 units in 500 ml D5NS to infuse over 3 hours per infusion pump.
- d. DC Oxytocin for 1 hour. D5NS at 125 ml/hr for 1 hour. Call Pharmacy to inform them when next bag is to be initiated.
- e. Oxytocin 150 units in 500 ml D5NS to infuse over 3 hours per infusion pump.
- f. DC Oxytocin for 1 hour. D5NS at 125 ml/hr for 1 hour. Call Pharmacy to inform them when next bag is to be initiated.
- g. Oxytocin 200 units in 500 ml D5NS to infuse over 3 hours per infusion pump.
- h. DC Oxytocin for 1 hour. D5NS at 125 ml/hr for 1 hour. Call Pharmacy to inform them when next bag is to be initiated.
- i. Oxytocin 250 units in 500 ml D5NS to infuse over 3 hours per infusion pump.
- j. DC Oxytocin for 1 hour. D5NS at 125 ml/hr for 1 hour. Call Pharmacy to inform them when next bag is to be initiated.
- k. Oxytocin 300 units in 500 ml D5NS to infuse over 3 hours per infusion pump.
- l. D5NS at 125 ml/hr after last bag of Oxytocin.

5. **Nursing Care:**

Permit for Vaginal Delivery/Cesarean Section  
Bedrest  
Vital signs q 1 hour  
Strict I&O q 4 hours

6. Notify Physician if undelivered at 24 hours and PRN.

7. Repeat Electrolytes and Hct at 24 hours if undelivered.

**MD Signature:** \_\_\_\_\_ **Date & Time:** \_\_\_\_\_

**Please use Ball Point Pen ONLY**