CULLMAN REGIONAL

PHYSICIAN'S ORDERS

Name Label Here

Authorization is hereby given to dispense the Generic or Chemical equivalent unless otherwise indicated by the words **"NO SUBSTITUTE"**

Dr. Fuller - Spine Kyphoplasty/Microdiscectomy Post Op Order Set

Principal Diagnosis:

Secondary Diagnosis:

Drug Allergies:

Post PACU: ❑ Admit Inpatient ❑ Place in Observation Services ❑ Outpatient

Medications

Available Meds After PCA/Epidural Discontinued OR NO PCA/Epidural

Mild Pain (scale 1-3)

❒ Toradol 15 mg IV q 6 hr x 48 hours, 1st dose at _____ (in PACU) if creatinine is < 1.5

❒ Acetaminophen 650 mg Po q 6 hours x 48 hours, 1st dose at _____ (in PACU)

Moderate Pain (scale 4-7)

❒ Norco 7.5 mg Po q 3 hours PRN

❒ Morphine 4 mg IV q 3 hours PRN

Severe Pain (scale 8-10)

❒ Dilaudid 1 mg IV q 4 hours PRN

If allergy exists to any above listed medications, call physician for additional orders.

❑ Zofran 4 mg IV q 6 hours PRN nausea/vomiting

❑ Benadryl 50 mg IV- Po q 6 hours PRN itching

Diet

- Clear/Full Liquids, advance to regular as tolerated

Post-Op Assessments

- Vital signs on arrival to room, every 1 hour x 2, then q 4 hours. Notify MD of significant changes.
- Pulses, capillary refill, sensation, and motor function checks q 15 minutes x 3, then q 1 hour.
- Dressing checked every 1 hour and PRN

Treatments and Interventions

❑ Begin Incentive Spirometry Protocol, notify Respiratory Therapy

- Turn, cough, deep breath q 2 hours x 48 hours while awake.
- Reinforce dressing with ABD pad if discharge is present; if saturated

❑ Out of bed with assistance, ambulate as tolerated

❑ Consult physical therapy.

❑ IV HepLock

❑ Ice bag to operative area PRN.

Additional Orders

❑ _____

_____

❑ _____

_____

Discharge Planning

❑ Discharge when outpatient meets criteria

❑ Keep until physician rechecks

❑ Return to office _____

❑ Check dressing prior to discharge

❑ May shower but **NO tub baths.**

❑ Remove dressing in _____days.

❑ Leave dressing in place until next office visit.

❑ Instruct Kyphoplasty/Microdiscectomy patients upon discharge to **not lift or bend for two weeks**. Otherwise, ambulate and activities as tolerated.

Physician's Signature: **Date/Time:**

Nurse's Signature: **Date/Time:**

Unit Secretary's Signature: **Date/Time:**