Your Hospital's Logo Here

PHYSICIAN'S ORDER SHEET

ALL ORDERS WILL BE FULFILLED UNLESS CROSSED OUT
AFTER EACH ORDER IS PROPERLY CHECKED, FAX ORDER SHEET TO PHARMACY WHETHER OR NOT ORDERS INVOLVE MEDICATION.

PATIENT IDENTIFICATION

Check (√) Each Order As Transcribed	Check (√) Pharmacy Orders	PATIENT SAFETY ORDER
		Physician (Print): ....
		DATE: **TIME:** (Military Time)
		Face-to-Face evaluation done by MD ☐ Yes ☐ No
		Alternative measures considered / attempted by Nursing Staff ☐ Yes ☐ No
		INDICATION ***(Check 1 Box ONLY)*** ☐ Patient interference with medical treatment *(24 hr time limit order)* (A) tubes, IV lines, etc. (B) "wandering" / elopement ☐ Risk for Falls ☐ Behavior Management EMERGENCY CRISIS *(4 hr time limit order)* ☐ Patient is violent or aggressive ☐ Patient is a serious danger to self / others
		TYPE OF RESTRAINT ***(Check ALL that apply)*** ☐ Soft Wrist Restraints ☐ Tuff Cuffs ☐ Vest ☐ Leather *(ED Only)* ☐ Hand Mitts ☐ Plastic *(ED & Seton House Only)* ☐ Torso Support ☐ Roll Belt
		BODY PART TO BE RESTRAINED ***(Check ALL that apply)*** ☐ Left Leg ☐ Torso ☐ Right Leg ☐ Left Wrist ☐ Right Wrist
		TIME PERIOD OF RESTRAINT ***START:*** (Military Time) Date ________________ Time ______________________ ***DISCONTINUE:*** (Military Time) Date ________________ Time ______________________ (Patient interference with medical restraint orders are limited to 24 hrs. Behavior management order for restraint is time limited to 4 hours for adults and 2 hours for adolescents & children. The RN may reassess patient and continue original order for a maximum of 24 hours).

FAXED BY/TIME:	TIME NOTED:	
Military Time > >		Doctor's Signature ______________________________,MD Date __________ Nurse's Signature / Title____________________________________

*** See Reverse Side for ALTERNATIVE MEASURES** **USE BALL POINT PEN ONLY - PRESS FIRMLY**

PART OF THE MEDICAL RECORD

EVALUATION TO BE CONSIDERED:

Nurse to assess
Vital signs check
CBC
Electrolytes, BUN / Creatinine
Urine C&S
Chest X-Ray, Lung Examination
Accucheck
Pulse oximetry
Fluid Intake
Observe for signs of trauma
Observe for signs of fecal impaction

STANDARD PRACTICE:

► Reorient patient frequently
► Keep the patient warm, dry, and comfortable
► Maintain conversation with patient, even if patient is confused
► Listen and validate patient's concern
► Explain procedures before touching the patient
► Establish eye contact when communicating with patient

ALTERNATIVE MEASURES TO BE CONSIDERED:

Tube Removal: Intravenous Line

Wrap the site and arm with an elastic bandage or stockinette. Cut window in the bandage for IV site viewing.
Tape bandage in place if patient disturbs it.
Consider using a capped IV line
Encourage oral intake when possible and reassess need for infusion
Use mittens instead of wrist restraints.
Sit patient in recliners to observe unit activities or involve in individual activities.

Foley Catheter

Discontinue if possible.
Hid tubing. Tuck top sheet to make it difficult for patient to slip hands under the sheet.
Use an activity apron (if available).
Place the tube between the legs and bag at the foot of the table.
Use leg bags if appropriate.
Use mittens instead of wrist restraints.
Use "dummy tube" to distract patient.

Nasal Tube

Use a nasal tube stabilizer.
Humidify the oxygen.
Lubricate the patient's nares.
Tape the cannulas to cheeks
Check pulse oximetry in room air and remove the tube if possible.
Provide mouth and nose care each shift and PRN.
Use mittens instead of wrist restraints when possible.

Abdominal Tube

Use a tube stabilizer, an abdominal binder, or both.
Use mittens instead of wrist restraints.
Continue to encourage patient with feeding tube if possible and periodically reassess need for tube.
Use "dummy tube" to distract patient.

Falls Risk

Help improve the patient's leg strength.
Obtain PT consult.
Offer a bedpan, urinal, or help patient to toilet every 2 hours (or in the morning, after meals, and at bedtime).
Use recliners and position patient where staff can easily observe patient, such as near nurse's station.
Use bed alarms.
Ask family members to sit with patient.

Wandering

Allow patient to walk around the unit with supervision
Offer a walker or assistive device.
Offer food and drink
Reorient patient and involve patient in constructive activities such as folding linens.
Distract patient by allowing patient to observe unit activities.