

PACU ANESTHESIA Provider's Order Sheet

| | | | |
|--|----------------------------------|--|--|
| 01 | MEDICATION RECONCILIATION | PACU Nurse has reviewed with ANESTHESIA Provider: | <input type="checkbox"/> Patient's current medication list <input type="checkbox"/> Medications taken by Patient on day of surgery |
| 02 | PAIN MANAGEMENT | For initial Pain Score equal to or greater than 4: | |
| <input type="checkbox"/> See PCA Order Sheet | | | |
| <input type="checkbox"/> Other: _____ | | | |
| <input type="checkbox"/> Fentanyl _____ mcg IV every _____ minutes; may repeat _____ times | | | |
| <input type="checkbox"/> Hydromorphone _____ mg IV every _____ minutes; may repeat _____ times | | | |
| <input type="checkbox"/> Morphine Sulfate _____ mg IV every _____ minutes; may repeat _____ times | | | |
| <input type="checkbox"/> Ketorolac __30__ mg IV x 1 dose | | | |
| <input type="checkbox"/> Acetaminophen __650__ mg PO x 1 dose | | | |
| <input type="checkbox"/> Tylenol #3; tab _____ / elixir _____ | | | |
| <input type="checkbox"/> Acetaminophen __325__ mg PO with Oxycodone __5__ mg (Percocet) _____ tablets PO x 1 dose | | | |
| 03 | HYPERTENSION | If diastolic BP exceeds _____, notify Anesthesia Provider and administer: | <input type="checkbox"/> Labetalol _____ mg IV: do NOT give if HR is less than 60 bpm <input type="checkbox"/> Hydralazine _____ mg IV: do NOT give if HR exceeds 90 bpm <input type="checkbox"/> Other: _____ |
| 04 | HYPOTENSION | If systolic BP is less than _____, notify Anesthesia Provider and administer: | <input type="checkbox"/> Ephedrine _____ mg IV x 1 dose <input type="checkbox"/> Neosynephrine _____ mcg IV x 1 dose <input type="checkbox"/> Other: _____ |
| 05 | NAUSEA and VOMITING | <input type="checkbox"/> Ondansetron (Zofran®) __4__ mg IV push x 1 <input type="checkbox"/> Dexamethasone __8__ mg IV push x 1 <input type="checkbox"/> Metoclopramide __10__ mg IV push x 1 <input type="checkbox"/> Diphenhydramine (Benadryl®) __12.5__ mg IV push x 1 | <input type="checkbox"/> Phenergan _____ mg IV x 1 dose <input type="checkbox"/> Other: _____ |
| 06 | LAB WORK | <input type="checkbox"/> Finger stick for blood glucose <input type="checkbox"/> STAT Gemstat (glucose, K+, Hb, ABG, Calcium) <input type="checkbox"/> STAT ABG <input type="checkbox"/> STAT 12 lead ECG | <input type="checkbox"/> STAT CXR <input type="checkbox"/> STAT Cardiac profile (serum troponin level, CPK with isoenzymes) <input type="checkbox"/> Other: _____ |
| 07 | IV FLUIDS | <input type="checkbox"/> Administer _____ at _____ ml / hour <input type="checkbox"/> Administer Hetastarch / Hespan _____ ml over _____ minutes <input type="checkbox"/> Transfuse PRBCs _____ units at _____ ml / hour <input type="checkbox"/> Transfuse platelets _____ units at _____ ml / hour <input type="checkbox"/> Transfuse FFP _____ units at _____ ml / hour | <input type="checkbox"/> Other: _____ |
| 08 | VENTILATOR ORDERS | Initial Ventilator Settings: | TV: _____ RR: _____ FiO2: _____ PEEP: _____ |
| <input type="checkbox"/> Do not extubate <input type="checkbox"/> Wean to T-Piece _____ % O2 <input type="checkbox"/> Anesthesia must be present for extubation <input type="checkbox"/> Extubate per unit protocol <input type="checkbox"/> Slow wean protocol | | | |
| 09 | SHIVERING and HYPOTHERMIA | <input type="checkbox"/> SHIVERING: Meperidine __12.5__ mg IV x 1 dose; may repeat x 1 if shivering persists <input type="checkbox"/> HYPOTHERMIA: if tympanic membrane temperature is less than 36.8: institute warming blanket <input type="checkbox"/> HYPOTHERMIA: if tympanic membrane temperature is less than 36.8: use fluid warmer | |
| 10 | DISCHARGE ORDERS | <input type="checkbox"/> Transfer to _____ on _____ liters / min O2 by nasal cannula <input type="checkbox"/> Notify Anesthesia Provider if O2 Sat is less than 95% for greater than 1 minute <input type="checkbox"/> Notify Anesthesia Provider for patient evaluation prior to discharge <input type="checkbox"/> May discharge when discharge criteria has been met | |
| DISCHARGE NOTES: _____ | | | |

| | | |
|---------------|---|---|
| PATIENT NAME: | ANESTHESIA PROVIDER Signature: | PACU RN Signature: |
| PATIENT SSN: | Print Name Date Pgr / Phone | Print Name Date Pgr / Phone |