UNIVERSITY OF MEDICAL CENTER

Pre-Printed Physician Orders for Anesthesiology Order In PACU/ASCU

MEDICATION ORDERS

Rx1 ☐ ORDER NOTED ☐ VERBAL ORDER | FIRST DOSE TIME | D/C DATE | NURSE'S SIGNATURE

MEDICATION OR FLUID	DOSE OR AMT	ROUTE	FREQUENCY
☐ Morphine Sulfate Hold for RR < 12/min or RASS - 2 Patient may have total of	_____ mg _____ mg	IV	q _____ min. in hr, PRN, for pain
☐ Fentanyl Hold for RR < 12/min or RASS - 2 Patient may have total of	_____ mcg _____ mcg	IV	q _____ min. in hr, PRN, for pain

DATE | TIME | M.D. SIGNATURE | M.D. ID NO

Rx2 ☐ ORDER NOTED ☐ VERBAL ORDER | FIRST DOSE TIME | D/C DATE | NURSE'S SIGNATURE

MEDICATION OR FLUID	DOSE OR AMT	ROUTE	FREQUENCY
☐ Dilaudid Hold for RR < 12/min or RASS - 2 Patient may have total of	_____ mg _____ mg	IV	q _____ min. in hr, PRN, for pain
☐ Demerol	_____ mg	IV	X 1 PRN post-op rigor
☐ Morphine Sulfate / Fentanyl drip 1 / hr for RASS (-2 to -3)	___ to ___ mg/mcg		

DATE | TIME | M.D. SIGNATURE | M.D. ID NO

Rx3 ☐ ORDER NOTED ☐ VERBAL ORDER | FIRST DOSE TIME | D/C DATE | NURSE'S SIGNATURE

MEDICATION OR FLUID	DOSE OR AMT	ROUTE	FREQUENCY
☐ Percocet / Roxicet	_____ mg	P.O.	X1 PRN, for pain
☐ Oxycodone / Roxicodone	_____ mg	P.O.	X1 PRN, for pain
☐ Dilaudid	_____ mg	P.O.	X1 PRN, for pain
☐ Ketorolac May repeat	_____ mg	IV	over 15 min q6h, PRN, for pain

DATE | TIME | M.D. SIGNATURE | M.D. ID NO

Rx4 ☐ ORDER NOTED ☐ VERBAL ORDER | FIRST DOSE TIME | D/C DATE | NURSE'S SIGNATURE

MEDICATION OR FLUID	DOSE OR AMT	ROUTE	FREQUENCY
☐ Metoclopramide May repeat with	_____ mg	IV	X ___ q ___ hr. PRN, N & V
☐ Ondansetron May repeat with	_____ mg	IV	X ___ q ___ hr. PRN, N & V
☐ Droperidol May repeat with	_____ mg	IV	X ___ q ___ hr. PRN, N & V
☐ Promethazine May repeat with	_____ mg	IV/IM/Rectal	X ___ q ___ hr. PRN, N & V

DATE | TIME | M.D. SIGNATURE | M.D. ID NO.

Rx5 ☐ ORDER NOTED ☐ VERBAL ORDER | FIRST DOSE TIME | D/C DATE | NURSE'S SIGNATURE

MEDICATION OR FLUID	DOSE OR AMT	ROUTE	FREQUENCY
☐ Midazolam Hold for RR < 12/min or RASS - 2 Patient may have total of	_____ mg _____ mg	IV	q _____ min in hr, PRN, for sedation
☐ Propofol drip per protocol for RASS -2 to -3			

DATE | TIME | M.D. SIGNATURE | M.D. ID NO.

IMPRINT ORDER SHEET WITH PATIENT'S ID PLATE BEFORE USING

NON-MEDICATION ORDERS

DATE	TIME		NURSE
		Allergies:	
		Vital signs (Per PACU policy)	
		Continuous ECG monitor and pulse oximetry	
		while in Adult PACU.	
		Continuous ETCO2 monitor if ventilated.	
		Supplemental Oxygen	
		Nasal Cannula ____ L/min	
		____ % ☐ Face Mask ☐ Face Tent	
		☐ Trach Collar ☐ Other: _____	
		Wean O_2 therapy per PACU policy	
		Ventilator Setting	
		Mode: ☐ Pressure Support: _____	
		☐ IMV: ____ ☐ Pressure Control: _____	
		☐ PEEP: ____ ☐ FIO2: ____ for SpO2 > 95%	
		☐ Wean to extubate per protocol _____	
		☐ Restraint	

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

UNIVERSITY OF MEDICAL CENTER

DEPARTMENT OF PHARMACY SERVICES – *PRESCRIBER'S ORDER*

1. All orders for antineoplastic agents must be written on the Antineoplastic Order Form.
2. All I.V. nutritional therapy must be written on the appropriate Parenteral Nutrition Order Form.
3. All systemic antimicrobials should be ordered on the Antimicrobial Order Form.
4. All patient controlled analgesia and epidurals should be ordered on the Acute Pain Management Service (APMS) form.
5. All Pediatric patients require weight-based dosing for medication.

PLEASE NOTE: It is required that the Prescriber's signature is provided on each Order. For multiple Orders in one Order session, it is required that the Prescriber's printed name, pager number, and ID # are provided on the first Order of each page of multiple Orders. At end of Ordering session, "X-out" Rx boxes not used.

WEIGHT HEIGHT ALLERGY

IMPRINT ORD[redacted]SING

MEDICATION AND I.V. FLUID ORDERS

Rx 1 Check If ☐ TRANSFER ☐ ADMIT ☐ POST OP ☐ VERBAL ORDER/Read Back Complete

MEDICATION OR FLUID (Generic Name)	DOSE OR AMT	ROUTE	FREQUENCY	INDICATION (Required for PRN or Range Order)

DATE	TIME	PRESCRIBER'S PRINTED NAME	PRESCRIBER'S PAGER#	PRESCRIBER'S ID#

NURSE'S SIGNATURE

PRESCRIBER'S SIGNATURE

Rx 2 Check If ☐ TRANSFER ☐ ADMIT ☐ POST OP ☐ VERBAL ORDER/Read Back Complete

MEDICATION OR FLUID (Generic Name)	DOSE OR AMT	ROUTE	FREQUENCY	INDICATION (Required for PRN or Range Order)

DATE	TIME	PRESCRIBER'S PRINTED NAME	PRESCRIBER'S PAGER#	PRESCRIBER'S ID#

NURSE'S SIGNATURE

PRESCRIBER'S SIGNATURE

Rx 3 Check If ☐ TRANSFER ☐ ADMIT ☐ POST OP ☐ VERBAL ORDER/Read Back Complete

MEDICATION OR FLUID (Generic Name)	DOSE OR AMT	ROUTE	FREQUENCY	INDICATION (Required for PRN or Range Order)

DATE	TIME	PRESCRIBER'S PRINTED NAME	PRESCRIBER'S PAGER#	PRESCRIBER'S ID#

NURSE'S SIGNATURE

PRESCRIBER'S SIGNATURE

Rx 4 Check If ☐ TRANSFER ☐ ADMIT ☐ POST OP ☐ VERBAL ORDER/Read Back Complete

MEDICATION OR FLUID (Generic Name)	DOSE OR AMT	ROUTE	FREQUENCY	INDICATION (Required for PRN or Range Order)

DATE	TIME	PRESCRIBER'S PRINTED NAME	PRESCRIBER'S PAGER#	PRESCRIBER'S ID#

NURSE'S SIGNATURE

PRESCRIBER'S SIGNATURE

Rx 5 Check If ☐ TRANSFER ☐ ADMIT ☐ POST OP ☐ VERBAL ORDER/Read Back Complete

MEDICATION OR FLUID (Generic Name)	DOSE OR AMT	ROUTE	FREQUENCY	INDICATION (Required for PRN or Range Order)

DATE	TIME	PRESCRIBER'S PRINTED NAME	PRESCRIBER'S PAGER#	PRESCRIBER'S ID#

NURSE'S SIGNATURE

PRESCRIBER'S SIGNATURE

NON-MEDICATION ORDERS

For ordering physician consults and for procedure/tests not yet available through PowerChart. For all other Orders, please use PowerChart.

DATE	TIME	Non-Medication Orders	Prescriber's Signature	Prescriber's Pager #	Prescriber's ID #	Nurse's Signature

(5/05)