

Your
Hospital's
Logo
Here

POST DELIVERY MAGNESIUM SULFATE ORDERS 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.

ADDRESSOGRAPH	Check (✓) Each Order As Transcribed	Check (✓) Pharmacy Orders	Allergy	
			PHYSICIAN'S ORDER	
			DATE:	TIME:
			Type of delivery: Vaginal: _____	C / S: _____
			Activity:	
			Diet:	
			IVF to total _____ ml per hour.	
			Pitocin 20 units in first liter of _____	
			Magnesium Sulfate 40 gm / L @ _____ gm / hr	
			Strict I & O x 24 hours	
			Foley catheter to gravity x 24 hours	
			Vital Signs: Per Nursing Protocol	
			Rhogam if indicated	
	FAXED BY/TIME:	TIME NOTED:	Doctor's Signature _____, MD Date _____	
		Nurse's Signature / Title _____		

ADDRESSOGRAPH	Check (✓) Each Order As Transcribed	Check (✓) Pharmacy Orders	Allergy	
			PHYSICIAN'S ORDER	
			DATE:	TIME:
			PAIN MANAGEMENT	
			Duramorph*: _____ PCA*: _____ Cont. Epidural*: _____	
			(* see attached order sheet): _____	
			Antibiotics: Start	
			D / C	
			Medications:	
			TEDS: Knee High: _____ Thigh: _____	
			Lab. Tests:	
	FAXED BY/TIME:	TIME NOTED:	Doctor's Signature _____, MD Date _____	
		Nurse's Signature / Title _____		

USE BALL POINT PEN ONLY - PRESS FIRMLY

PART OF THE MEDICAL RECORD