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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	GASTRIC BYPASS POST OP - CLINICAL PATHWAY: DAY 1
		DAY 1 — PAGE 1 of 3
		Allergy
		MONITORING — **DATE:** **TIME:** (Military Time)
		ADMIT TO:
		DIAGNOSIS:
		ACTIVITY — ☐ Ambulate in hall on day of surgery; continue 4 times each day and document
		☐ Vitals every 4 hours
		☐ Strict I&O every 8 hours
		☐ Call Surgical HO and/or Attending MD for questions or clarifications
		TEST — ☐ X-RAY: UGI (Gastro Graffin) in AM at 0730 R/O anastomotic leak
		☐ LAB: CBC in AM
		☐ CMP in AM
		DIET — ☐ When fully awake, may start [1] sips of water, [2] ice chips, and/or [3] sugar-free popsicles ONLY
		IV FLUIDS — ☐ 0.9% Sodium Chloride (Normal Saline) IV at 100ml/hour
		☐ IV Fluid _____ at _____ ml/hr (rate)
		☐ Add 1 amp Multivitamin (MVI) to 1 liter IV fluids per day
		☐ Add 1 mg Folic acid to 1 liter IV fluids per day
		☐ Dextran 40/0.9% Sodium Chloride IV at 25ml/hour times 1 liter
		☐ Discontinue Dextran
		☐ Reglan 10mg IVPB TID
		☐ Fragmin 5000 units subcutaneous daily. Start at _____ if no bleeding at site.
		Continued ☐ Pepcid 20mg IVPB every 12 hours
		☐ Ativan 0.5mg IVP every 6 hours PRN as needed for anxiety
		☐ Zofran 4mg IVPB every 6 hours PRN as needed for nausea and vomiting
		< ☐ Ancef 1gm IVPB every 8 hours times 2 doses > > **DO NOT give if allergic to PCN.**
		< ☐ If allergic to PCN, give Levaquin 500mg IVPB every 24 hours times two doses
		☐ Vasotec 1.25mg every 4 hours PRN for systolic greater than 160 or diastolic greater than 90

FAXED BY/TIME: **TIME NOTED:**

Doctor's Signature _____,MD Date _____

Nurse's Signature / Title_____

Military Time > >

USE BALL POINT PEN ONLY - PRESS FIRMLY

PART OF THE MEDICAL RECORD

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PATIENT IDENTIFICATION

Check (√) Each Order As Transcribed	Check (√) Pharmacy Orders	GASTRIC BYPASS POST OP - CLINICAL PATHWAY: DAY 1
		DAY 1 — PAGE 2 of 3
		Allergy
		IV FLUIDS ☐ Glucose check (accucheck) every ac and every hs, per sliding scale below: 60 or less: give 2 amps D50 and call HO 61 to 150: give 0 units 151 to 250: give 3 units of regular insulin subcutaneous 251 to 300: give 6 units of regular insulin subcutaneous 301 to 350: give 10 units of regular insulin subcutaneous 351 or greater: give 12 units and call HO
		PAIN MEDICATIONS ☐ Morphine 4mg IV every 2 hours as needed for pain
		☐ If allergic to Morphine, give Dilaudid 4mg IV every 2 hours PRN for pain
		☐ Toradol 30mg IVPB every 6 hours for 24 hours
		☐ Tylenol with Codeine Elixir 15ml PO every 4 hours as needed for pain
		☐ Ibuprofen suspension 60mg/30ml PO every 4 hours as needed for pain
		☐ PCA Morphine (see attached PCA order sheet)
		TREATMENTS ☐ Sequential pneumatic compression stockings while in bed
		☐ Assess incision site and change dressing as needed
		☐ Assess patient for signs and symptoms of leakage from anastomosis: HR greater than 20 beats per minute above baseline, respiratory rate greater than 6 breaths per minute above baseline. If patient symptomatic: notify surgeon immediately, stop Dextran, do stat CBC and pulse ox.
		☐ Discontinue Foley Catheter 12 hours post-op
		RESPIRATION TREATMENTS:
		☐ CPAP/Bi-pap as per pulmonologist Dr. _____
		☐ Incentive spirometry exercises 10x every hour while awake
		☐ Encourage coughing and deep breathing
		☐ Chest PT every 8 hours
		☐ Proventil Nebs 1 unit dose every 6 hours
		☐ Respiratory Care to evaluate and obtain baseline pulse ox and provide supplemental O2 per protocol.
		NEXT PAGE ↓

FAXED BY/TIME:

TIME NOTED:

Doctor's Signature _____,MD Date _____

Nurse's Signature / Title_____

Military Time > >

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PATIENT IDENTIFICATION

Check (√) Each Order As Transcribed	Check (√) Pharmacy Orders	GASTRIC BYPASS POST OP - CLINICAL PATHWAY: DAY 1 — DAY 1 — PAGE 3 of 3
		Allergy
		CONSULTS ☐ PT for evaluation
		☐ OT for ADL's evaluation
		☐ Dietitian for diet instructions
		☐ Pharmacy for medication review and changes
		☐ Case Management for discharge planning
		CALL MD/SURGEON FOR ***CALL MEDICAL DOCTOR / SURGEON FOR:***
		☐ SOB
		☐ Respiratory Rate greater than 20
		☐ Oxygen Saturation less than 92%
		☐ Temp greater than 101.5
		☐ Confusional State
		☐ Notify MD for HR greater than 20 bpm above baseline
		NOTES:

FAXED BY/TIME:

TIME NOTED:

Doctor's Signature _____,MD Date _____

Nurse's Signature / Title_____

Military Time > >

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