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# PHYSICIAN'S ORDER SHEET

PRE - OP ORDERS

PATIENT IDENTIFICATION

| ABBREVIATIONS |                    | Check (✓)<br>As<br>Transcribed | ALLERGY                                  |                            |              |
|---------------|--------------------|--------------------------------|--|----------------------------|--------------|
| DO NOT<br>USE | USE                |                                | INDICATE RATIONALE FOR MEDICATION ORDERS |                            | RATIONALE    |
| QD            | Daily              |                                | Date:                                    | Time:                      |              |
|               |                    |                                | REGLAN 10 mg                             |                            |              |
| QOD           | Every<br>Other Day |                                | PEPCID 20 mg                             |                            |              |
|               |                    |                                | BICITRA 30 ml                            |                            |              |
| QID           | 4 Times<br>a Day   |                                | ** Give the above "ON-CALL" to the O.R.  |                            |              |
| U             | Units              |                                |  |                            |              |
| UG            | Microgram          |                                |  |                            |              |
| CC            | ML                 |                                | Physician's Signature / Title:           |                            | Date: Pager: |
|               |                    |                                | M.D.                                     |                            |              |
|               |                    |                                | Faxed By/Time:                           | NURSE'S Signature / Title: | Date: Time:  |

|                            |                      |  |                                |                            |              |
|----------------------------|----------------------|--|--------------------------------|----------------------------|--------------|
| .2mg                       | 0.2mg                |  | Date:                          | Time:                      |              |
| 10.0mg                     | 10mg                 |  |                                |                            |              |
| MS or<br>MSO <sub>4</sub>  | Morphine<br>Sulfate  |  |                                |                            |              |
| MG or<br>MgSO <sub>4</sub> | Magnesium<br>Sulfate |  |                                |                            |              |
| OS                         | Left<br>Eye          |  |                                |                            |              |
| OU                         | Both<br>Eyes         |  |                                |                            |              |
| OD                         | Right<br>Eye         |  |                                |                            |              |
| AS                         | Left<br>Ear          |  | Physician's Signature / Title: |                            | Date: Pager: |
|                            |                      |  | M.D.                           |                            |              |
| AU                         | Both<br>Ears         |  | Faxed By/Time:                 | NURSE'S Signature / Title: | Date: Time:  |
| AD                         | Right<br>Ear         |  |                                |                            |              |