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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	TOTAL (Left or Right) Hip ARTHROPLASTY - CLINICAL PATHWAY DAY 1 DRG #209 PAGE 1 of 2
		CROSS THROUGH AND INITIAL ORDERS NOT APPLICABLE
		DATE: **TIME:** (Military Time)
		ADMIT PATIENT TO:
		DIAGNOSIS:
		ACTIVITY:
		1. Bedrest (day of surgery)
		2. OOB chair BID (Beginning POD #1)
		3. Weight bearing status _____
		LABS:
		1. CBC in PACU and Q am x 3
		2. PT and INR Q am
		RADIOLOGY: A.P. & Lat of _____LEFT _____RIGHT Hip in PACU (check one)
		DIET: Advance as tolerated Post-Op
		MEDICATIONS: (check options or cross out)
		Lovenox 30 mg S.Q. B.I.D. 1st Dose TIME: DATE:
		Coumadin _____ mg 1st Dose TIME: **1800 Hours** DATE:
		Antiemetic prn _____ (Drug Name) _____ Route, Dose & Timing
		Laxative / Stool softener _____ (Drug Name) _____ Route, Dose & Timing
		Antibiotics _____ (Drug Name) _____ Route, Dose & Timing
		Antibiotics _____ (Drug Name) _____ Route, Dose & Timing
		Antibiotics _____ (Drug Name) _____ Route, Dose & Timing
		OTHER MEDICATIONS:

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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		DATE: **TIME:** (Military Time)
		PAIN MANAGEMENT: (check options or cross out)
		☐ Epidural pain management [See Acute Pain Service (APS) orders for Epidural & Intrathecal Analgesia] **-OR-**
		☐ _____ (Drug Name) _____ (Route, Dose & Timing)
		TREATMENTS: (check options or cross out)
		☐ I & O q 8 hours
		☐ Encourage coughing and deep breathing q 1 hour while awake
		☐ Turn and reposition q 2 hours
		☐ Position foot of bed and gatch knee of bed
		☐ Ice to operative site
		☐ Pneumatic compression device _____ **Pleipulse** or _____ **SCUDS** (check one)
		☐ Bilateral long TEDS
		☐ Abduction Pillow & Hip precautions
		☐ Auto-transfusion (transfuse within 4 hours, may repeat x1, then convert to hemovac)
		☐ Foley catheter if unable to void within 8 hours Post-Op
		☐ Incentive Spirometer q 1 hour while awake
		IV: _____ at _____ ml/hr continuously. Convert to saline lock once tolerating PO fl
		VITAL SIGNS q 8 hours
		PHYSICAL THERAPY consult for ambulation and strengthening exercises, starting POD #1, & q day thereafter. Teach Hip precautions.
		OCCUPATIONAL THERAPY consult for ADL's to start POD #1 & q day thereafter
		SOCIAL SERVICE & CASE MANAGEMENT (CM) consults for D/C planning

FAXED BY/TIME:	TIME NOTED:	Doctor's Signature _____,MD Date _____ Nurse's Signature / Title_____

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