

PENINSULA REGIONAL MEDICAL CENTER

ALLERGIES _____

DATE/ TIME	POST-ANESTHESIA PAIN PACU DOCTOR'S ORDERS	INITIALS
	Pain Medication: (check one)	
	<input type="checkbox"/> Morphine <input type="checkbox"/> Hydromorphone (DILAUDID)	
	_____ mg IV every _____ min. x _____ PRN if RR ≥ 10.	
	Fentanyl _____ mcg every _____ min. x _____ IV PRN if RR ≥ 10.	
	Promethazine (PHENERGAN) 12.5 mg IV PRN nausea. May repeat X1.	
	If Promethazine fails to relieve nausea:	
	Ondansetron (ZOFTRAN) _____ mg IV x 1	
	Ephedrine _____ mg IM x 1	
	Hydroxyzine (VISTARIL) _____ mg IM x 1	
	If patient's O ₂ SAT is < _____ on room air, place on	
	O ₂ _____ via nasal cannula overnight.	
	Meperidine (DEMEROL) _____ mg IV every _____ min PRN shivering May repeat X _____.	



074