

DATE/TIME: \_\_\_\_\_ VS: Temp: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_ Pulse Ox: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

OLD RECORDS  Hosp Chart  OLD EKG  ED Chart

LABS:

<input type="checkbox"/> CBC	<input type="checkbox"/> Retic	<input type="checkbox"/> CIEP	<input type="checkbox"/> PT	<input type="checkbox"/> PTT	<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> T+S
<input type="checkbox"/> BMP		<input type="checkbox"/> Troponin I	<input type="checkbox"/> Amylase	<input type="checkbox"/> ASA	<input type="checkbox"/> T+C	Units
<input type="checkbox"/> CMP		<input type="checkbox"/> Myoglobin	<input type="checkbox"/> Lipase	<input type="checkbox"/> Dilantin		
<input type="checkbox"/> Mg++		<input type="checkbox"/> CRP	<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> Digoxin		<input type="checkbox"/> U/A
<input type="checkbox"/> BHCG qual (Serum)		<input type="checkbox"/> TSH	<input type="checkbox"/> ETOH	<input type="checkbox"/> CSF Panel		<input type="checkbox"/> U/A Dip
<input type="checkbox"/> BHCG qual (Urine)			<input type="checkbox"/> CPK			<input type="checkbox"/> Cath U/A
<input type="checkbox"/> BHCG quantitative (Serum Only)						<input type="checkbox"/> Urine Tox

CULTURES:

<input type="checkbox"/> Urine C+S confirm in lab	<input type="checkbox"/> RSV	<input type="checkbox"/> Influenza	<input type="checkbox"/> GC	<input type="checkbox"/> Chlamydia	Stool:
<input type="checkbox"/> BCX _____	<input type="checkbox"/> Sputum C+S		<input type="checkbox"/> Wet Prep uretha _____		<input type="checkbox"/> Stool C+S
<input type="checkbox"/> Throat/Quik Strept	<input type="checkbox"/> C+S/gm stain _____	(Site)	<input type="checkbox"/> cervix _____		<input type="checkbox"/> Rotavirus
					<input type="checkbox"/> O+P <input type="checkbox"/> Fecal WBC
					<input type="checkbox"/> Cdif Toxin

RESPIRATORY:

<input type="checkbox"/> Pulse OX _____ Results	<input type="checkbox"/> Continuous Nebulization	<input type="checkbox"/> Albuteral NEB q _____ min x _____	<input type="checkbox"/> Peak flow pre/post _____ Results
<input type="checkbox"/> Respiratory Consult	<input type="checkbox"/> Sputum Induction	<input type="checkbox"/> Atrovent NEB	<input type="checkbox"/> MDI Teaching <input type="checkbox"/> ABG <input type="checkbox"/> w/lytes

NURSING:

<input type="checkbox"/> O <sub>2</sub> @ _____ NC, NRB	<input type="checkbox"/> Cardiac Monitor	<input type="checkbox"/> BP Monitor	<input type="checkbox"/> Pulse Ox Continuous
<input type="checkbox"/> Saline Lock	<input type="checkbox"/> Foley Cath	<input type="checkbox"/> Residual	<input type="checkbox"/> Orthostatic VS Results _____
IV: <input type="checkbox"/> LR <input type="checkbox"/> NS <input type="checkbox"/> D5LR <input type="checkbox"/> D5.45 <input type="checkbox"/> w/ _____ meq Kcl/L	<input type="checkbox"/> Accucheck _____ results.		
<input type="checkbox"/> Large Bore <input type="checkbox"/> @ _____ cc/hr.	<input type="checkbox"/> Bolus _____ cc		

Time	MD Initials	ORDERS	COMPLETED	
			Time	Initial
		<input type="checkbox"/> See Xray Order <input type="checkbox"/> See Standing Order		
		<input type="checkbox"/> EKG		
		<input type="checkbox"/> Td 0.5mg. IM Manufact.: _____ Lot#: _____ Exp. Date: _____		

Calls: Name/Number	Time 1st Call	Time 2nd Call	Time 3rd Call	Returned Call	SIGNATURE/TITLE: MD, RN, PA	INITIAL

HEALTHCARE  
Hospital

**EMERGENCY DEPARTMENT  
PHYSICIAN ORDER RECORD**

Addressograph