



ORD

ORDERED		ORTHOPAEDIC SURGERY ADMISSION ORDERS	TIME
DATE	TIME		ORDER NOTED
		<i>Check appropriate boxes.</i>	
		Dr. <input type="checkbox"/> Altmeyer <input type="checkbox"/> Jones <input type="checkbox"/> Linton <input type="checkbox"/> Rhea	
		Diagnosis: <input type="checkbox"/> Left <input type="checkbox"/> Right _____	
		Vital Signs every 8 hours with neurovascular checks on affected extremity	
		<b>IVF:</b> <input type="checkbox"/> LR <input type="checkbox"/> 1/2 NS Rate: <input type="checkbox"/> 50cc/hr <input type="checkbox"/> 75 cc/hr <input type="checkbox"/> _____	
		<b>Diet:</b> <input type="checkbox"/> NPO after Midnight <input type="checkbox"/> Preop Diet <input type="checkbox"/> NPO <input type="checkbox"/> _____	
		<b>Consult:</b> <input type="checkbox"/> Hospitalist <input type="checkbox"/> Surgery Clearance <input type="checkbox"/> Condition: _____	
		<input type="checkbox"/> Other: _____ <input type="checkbox"/> OK to see Post-Op	
		<input type="checkbox"/> Hospitalist to reconcile Home Medications and prescribe.	
		<b>Labs:</b> <input type="checkbox"/> CBC <input type="checkbox"/> BMP <input type="checkbox"/> Type & Screen <input type="checkbox"/> PT/PTT <input type="checkbox"/> U/A <input type="checkbox"/> ABG <input type="checkbox"/> CXR	
		<input type="checkbox"/> EKG <input type="checkbox"/> Type and Crossmatch 2 units PRBCs	
		<input type="checkbox"/> Buck's Traction 5 lbs to affected leg <input type="checkbox"/> Elevate affected extremity	
		<b>DVT Prophylaxis:</b> <input type="checkbox"/> SCDs <input type="checkbox"/> TEDs <input type="checkbox"/> AV Impulse	
		<input type="checkbox"/> Warfarin (Coumadin) <input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5.0 mg <input type="checkbox"/> Other dose: _____ PO every HS	
		For Coumadin, consult Pharmacy for drug interaction and education.	
		For Coumadin, Daily INR, Hold Coumadin if INR > 3.0	
		<input type="checkbox"/> Enoxaparin (Lovenox) 30 mg SQ every 12 hours. Daily Platelet Count.	
		<input type="checkbox"/> Fondaparinux (Arixtra) 2.5 mg SQ every day	
		<b>Operative Permit for:</b>	
		Op Permit for Dr: <input type="checkbox"/> Altmeyer <input type="checkbox"/> Jones <input type="checkbox"/> Linton <input type="checkbox"/> Rhea	
		Pre-Op Antibiotic: <input type="checkbox"/> Cefazolin (Ancef) 1 gm IV in OR within 1 hour of incision	
		<input type="checkbox"/> Vancomycin 1 gm IV on call to OR within 2 hours of incision (check reason below)	
		<input type="checkbox"/> Documentation of beta-lactam allergy (penicillin or cephalosporin)	
		<input type="checkbox"/> Known prior colonization with MRSA	
		<input type="checkbox"/> High risk due to acute inpatient hospitalization within last year	
		<input type="checkbox"/> High risk due to nursing home or extended care facility within last year, prior to admission	
		<input type="checkbox"/> Increased MRSA rate, either facility-wide or operation-specific	
		<input type="checkbox"/> Chronic wound care or dialysis	
		<input type="checkbox"/> Continuous inpatient stay more than 24 hours prior to the principal procedure	
		<input type="checkbox"/> Other documented reason:	
		<input type="checkbox"/> Patient on Beta Blocker, give _____ preop with sips of water.	
		<b>PRN Meds:</b> <input type="checkbox"/> Acetaminophen (Tylenol) 325 mg 1-2 every 4 hours PO PRN mild pain or temp > 101	
		<input type="checkbox"/> Propoxyphene Napsylate 100mg/acetaminophen 650mg (Darvocet N) 1-2 PO every 4 hours for moderate pain; may increase to 2 tabs as needed.	
		<input type="checkbox"/> Hydrocodone 7.5mg/acetaminophen 500 mg (Lortab) PO PRN severe pain	
		<input type="checkbox"/> Ondansetron (Zofran) 4 mg IV every 4 hours PRN nausea/vomiting	
		<input type="checkbox"/> Bisacodyl (Dulcolax) suppository if no BM for 3 days	
		<input type="checkbox"/> Morphine <input type="checkbox"/> PCA: Morphine – Pharmacy to dose	
		<input type="checkbox"/> Bladder scan if unable to void. If > _____ cc, straight cath every 8 hours.	
		Social Work Consult: <input type="checkbox"/> Equipment needs <input type="checkbox"/> D/C Planning <input type="checkbox"/> Post-Hospital Placement	
		<input type="checkbox"/> TB Skin Test: administer and read	
		Physician Signature: _____ Date/Time: _____	

▼ Addressograph / Patient Label ▼



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