

Lakeview Clinic General Surgery Scheduling Request Form

Please Check Site: Chaska Fax # 952-556-2668 (If RMC clinic extension 2668)
 RMC Fax # 952-442-8029

Person Completing Request: _____ Feb-10

Date of Surgery: _____ Time Requested: _____ AM PM

Patient Name: last _____ first: _____

Date of Birth _____ Male Female

Admission Type: SDS AA Accommodating Current In-Patient

Race: White Black Hispanic Asian American Indian Other

Home Phone: _____ Cell: _____
 Work: _____ Other: _____

Special Phone Instructions: _____

Permission to give instructions to: (spouse/friend/child) _____ Phone#: _____

Parent's name: Mother: _____ Father: _____

Same last name (* need parent names for children under 18 yrs)

Surgeon: _____ Assistant(s): _____

Procedure: (no abbreviations) _____

AA Major Procedure AA Minor Procedure SDS Laparoscopy SDS Hernia Pediatric SDS

SDS Hemorrhoidectomy AA Mastectomy SDS Signed: _____

Time needed for procedure: _____ Need nurse assist? _____

Anesthesia Type: General Spinal Epidural Regional MAPS Local None

Referring M.D./Clinic doing H&P: _____
 Insurance: _____

Need Intra-op X-rays ? C-Arm Regular x-ray

Previous x-rays coming from? RMC PACS

Mammograms done @: _____
 * Intra-op x-rays at Chaska need prior approval

Special Requests: _____

Interpreter needed? No Yes

Language _____

** Family or friend cannot interpret health information**

Comments: _____

Scheduled by: _____ Date: _____ Confirmed By FAX _____

To be retained in hospital medical record as Surgery Record (SR)

Order Date: _____

Ordering MD please initial here if this page is modified: _____

When completed, please DICTATE OR FAX ALL PAGES
Please DICTATE to: 952-442-2191 ext 6500
Please FAX TO THE CORRECT LOCATION: **RMC Waconia SDS:** 952-442-8068 **-or- RMC Chaska SDS:** 952-556-2621

Patient Name: _____ DOB: _____ Age: _____ Sex: ___M ___F
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Surgery: _____ Primary Care MD: _____ Phone: _____
Surgical Procedure: _____ Surgeon: _____

HISTORY	Chief complaint/History of present illness: _____
Patient has health care directive or living will? [] Yes [] No	

PAST MEDICAL HISTORY	Steroids in last 6 months? [] Yes [] No	Asprin/Coumadin within 10 days? [] Yes [] No
1		
2		
3		
4		
5		

PAST SURGICAL HISTORY	
1	
2	
3	
4	

ANESTHESIA COMPLICATIONS			
	Prolonged Reversal		Hyperthermia

ALLERGIES		
	Drug	Reaction
1		
2		
3		
4		
5		
6		

Ridgeview Medical Center
**ADULT PRE-SURGICAL
HISTORY & PHYSICAL**



Order Date: _____

Ordering MD please initial here if this page is modified: _____

Patient Name (required for faxing): _____ DOB: _____

PHYSICAL EXAM		✓ ** Look for skin infections/abnormalities **			
General Appearance	Normal				
HEENT	Normal				
Heart	Normal				
Lungs/Chest	Normal				
Abdomen	Normal				
Extremities	Normal				
Neurological	Normal				
Breast	Normal				
GU	Normal				
Other	Normal				
Height	Weight	Pulse	BP	Temp	
Respirations	Pulse Ox	MRSA	VRE	AIDS	TB
Summary/Comments:					

RISK ASSESSMENT	
<input type="checkbox"/> High (or indeterminate) risk for death (i.e. Aortic Stenosis, active CHF, MI <6 months, O2 dependent lung disease)	
<input type="checkbox"/> Intermediate	<input type="checkbox"/> Cardiac (presence of 1 or more stable HTN, DM, CAD, AF or CHF) <input type="checkbox"/> Non-Cardiac (alcohol use, renal, pulmonary, immune suppressed, history DVT/PE, constipation, delirium risk, bleeding)
<input type="checkbox"/> No additional modifiable risk identified	

RECOMMENDATIONS	
<input type="checkbox"/> Proceed with Surgery	<input type="checkbox"/> Additional screening recommended:
<input type="checkbox"/> Consult: (cardiology/other)	
<input type="checkbox"/> Special orders have been attached to this H&P	
<input type="checkbox"/> Additional test results have been attached to this H&P	
<input type="checkbox"/> Pending Labs	

This patient has been examined by me today & has been found to be a suitable candidate for surgery with the exceptions noted above.

Print Name & Title	Signature	Date	Time	Phone

Ridgeview Medical Center
**ADULT PRE-SURGICAL
 HISTORY & PHYSICAL**

Acebutolol
Atenolol
Betagan
Betaxolol
Betoptic
Bisoprolol
Blocadren
Brevibloc
Bystolic
Carteolol
Cartrol
Carvediol
Coreg
Corgard
Corzide
Esmolol
Inderal

Inderide
InnoPran XL
Kerlone
Labetalol
Levator
Levobunolol
Lopressor
Lopressor HCT
Metipranolol
Metoprolol
Nadolol
Nebivolol
Nebivolol
Normodyne
Ocupress
OptiPranolol
Penbutolol

Pindolol
Pindolol
Propranolol
Sectral
Senormin
Sotalol
Tenoretic
Tenormin
Timolide
Timolol
Toprol-XL
Trandate
Trandide
Visken
Zebeta
Ziac

Time of Surgery _____ **Admission Time:** _____ Approx. discharge time: _____

() Scheduled procedure correct & verified with patient. If not, notify OR charge nurse.

() If applicable: _____ has crutches – knows how to use _____ self cath teaching done preop at clinic.

() May eat light food until _____ May drink clear liquids until _____. () N/A if local

() You will need a driver. Who is your driver? _____ You should have a responsible adult with you for 24 hours after surgery & should not go home alone () N/A if local

() Please shower/bathe/brush your teeth before coming. We ask that you wear no make up & use no hair products, no jewelry & body piercings. Please do not shave the surgical area.

() Leave your valuables at home. Do bring reading glasses, hearing aides & dentures, if you use them. Contact lenses cannot be worn during surgery. Please wear loose comfortable clothing. (Button down, zip front shirt if necessary for breast or shoulder patients.)

() Bring your anesthesia questionnaire, photo id, insurance card, photo ID, prescription card, and paperwork from your doctor. InstyMeds dispenser if you choose to use it. The cost is the same as your pharmacy.

Peds Patients: () NA Immunizations up to date: Y / N Has patient had chicken pox: Y / N Vaccinated: Y / N Has patient been exposed in past 3 weeks? Y / N Parents/legal guardian must stay in the waiting room while the child is in surgery & until child is returned to room. We ask that other siblings do not come. We recommend to bring own sippy cups, toys, videos, or items of comfort. For parents there is a refreshment vending machine and you may pack a snack to eat in the waiting room if you wish.

AA PATIENTS: () NA Do you have sleep Apnea? Y / N. Please bring your c-pap machine along with you to the hospital. Bring all home meds in their original containers.

Preop prep: _____ Fleets enema _____ Colon Prep

TOTAL HIP/KNEE PATIENTS: () NA Did you attend the class? Y / N Bactroban to nares started: Y / N Hexaclens shower: Y / N Fleets enema: Y / N. Your family can bring up suitcase & walker/crutches up to room after surgery.

Have you had any recent exposure to any communicable diseases (hepatitis, TB, shingles)? Y / N

Have you ever been told you have MRSA? Y / N If yes, when? _____ Infection site _____

Do you have any handicaps or special needs? Y / N _____

Have you had any recent dental infections? Y / N Are you being treated for this? Surgeon notified? Y / N

Do you use tobacco? Y / N In last year? Y / N If so what & how much per day? _____

() NA Are you pregnant? Y / N Are you breast feeding? Y / N If yes, bring your breast pump.

() NA minor. Do you have a HCD? Y / N please bring a copy along to the hospital. If already on file, verified in HPF _____

() Preop physical done () N/A if local. () Yes () No () Pt. will schedule

Dr. _____ Clinic _____ Date: _____ Lab: _____ EKG: _____

What is your weight _____ lbs.

Ridgeview Medical Center
SDS Preop Phone Call Questionnaire

#10629 (3/11) Side 1



3PINS

Allergies:

Latex: Y / N Reaction: _____

Medications: Y / N: Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____

Diabetic Y / N: Diet Controlled Y / N

Do you take any medications at home, including inhalers, aspirin, vitamins and supplements: Y / N?

Name	Dose	Frequency	Reason for taking	Notes/Last dose

- () If patient has not been off Coumadin 3 days? Y / N Surgeon notified? Y / N
- () Patient reminded to follow instructions from surgeon or primary MD regarding home meds. Please bring any inhalers with you to the hospital.
- () Patient to contact doctor's office if they become significantly ill (fever, flu, URI)
- () Transfer patient to admitting ext. 5110 or 5111 if patient has not registered with business office.
- () All questions answered

Date/Time: _____ Spoke with: _____ Nurse completing preop call: _____

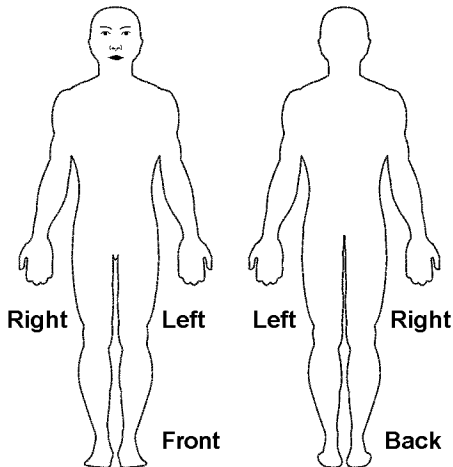
Date: _____

Signature of nurse
completing task

Time

		1. Correctly identify patient using 2 identifiers: (check which 2 methods were used)
	AM / PM	<input type="checkbox"/> Name by verbal confirmation with patient/caregiver/guardian <input type="checkbox"/> Birthdate <input type="checkbox"/> ID Wristband <input type="checkbox"/> Patient's medical record/Visit ID/Medical Record number <input type="checkbox"/> Patient's address <input type="checkbox"/> Photo of patient
	AM / PM	2. <input type="checkbox"/> Consent correct, timed, dated and signed
	AM / PM	3. <input type="checkbox"/> IV started & Labeled, Documented in IV management
	AM / PM	4. <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has family waiting
	AM / PM	5. Correct surgical site(s) and procedure(s) verified with: (check all as completed)
	AM / PM	<input type="checkbox"/> Patient <input type="checkbox"/> Surgical Consent <input type="checkbox"/> Surgery Schedule <input type="checkbox"/> Medical Record
	AM / PM	6. <input type="checkbox"/> Surgeon marked skin adjacent to the surgical site(s) using their initials <input type="checkbox"/> On Body Diagram, mark the Surgical Site(s) using an X ; if applicable <input type="checkbox"/> Skin mark not required for this procedure

Level one hard stop has been completed and/or reconciled, the patient may be released to the operating room.



*** Bilateral procedure sites do not require site marking**

Body diagram may be used for difficult to mark sites as listed, or when patients refuse skin mark:

- Teeth/oral procedures
- Ovary when procedure is vaginal approach
- Scrotal procedures
- Ureter/kidney when procedure is via urethra
- Vaginal/urethral/rectal approach procedures
- Unilateral myringotomy with tube
- Tonsils

Surgeon Signature

Date

Time

Ridgeview Medical Center
HOLDING ROOM
PRE-SURGICAL VERIFICATION CHECKLIST

#09165 3/11



Nerve Block & Procedure Record

Requested by Dr. _____ for post-op analgesia **MDA ID** _____ **Start Time** _____ **Stop Time** _____
 Performed by _____ in: Holding Rm PACU in OR

Site Verification Checklist Block site marked by performing MDA N/A
 Patient ID'd 2 ways Verbal affirmation all supplies/equipment are available
 Procedure, site, position & block site verified Pre-procedural "time out" was done

Any discrepancy must be reconciled prior to proceeding

Peripheral Nerve Block Aseptic technique used Anatomic Approach _____
 Needle Used: Stimplex 22ga. Ins Touhy 18 Ga. Ins Touhy 20ga. Ins
 At a depth of _____ cm perpendicular angled Nerve stimulation of Brachial Plexus nerve Femoral Nerve Other _____
 Using a needle current as low as _____ mA caused motor contraction of _____
 After negative aspiration for Blood CFS a total of _____ ml of: 0.5% Ropivacaine _____ was injected incrementally with aspiration checks

Epidural Catheter Placement Using aseptic technique an 18 g Touhy needle was advanced medially paramedially toward the EDS. LOR at a depth of _____ cm.
 ED catheter advanced to _____ cm. Wet tap +/- Paresthesia +/- Test dose +/- _____

Procedure POEA Start Date _____ Initial bolus _____ and rate _____ End Date _____ Total Days _____
 Art Line CVC Line CFS Tap ED Blood Patch EDSI@ _____ Other _____
 36625 36556 62270 62273 62310/11
 Intubation Extubation Ventilator management Patient location _____ time _____ to _____
 Invasive monitoring discussed
 Cap, mask, sterile gown & gloves, large sterile sheet, hand hygiene, 2% CHG for cutaneous antiseptics
 If not timely Medical reason NOS

Post-op Patient Visits	Date	Analgesia Level	Events	Adjustments	MDA
		Good 0-4 Fair 5-7 Poor 8-10			
		Good 0-5 Fair 5-8 Poor 8-11			
		Good 0-6 Fair 5-9 Poor 8-12			
		Good 0-5 Fair 5-8 Poor 8-11			
		Good 0-6 Fair 5-9 Poor 8-12			
		Good 0-7 Fair 5-10 Poor 8-13			

I have personally reviewed the pre-op H&P, and obtained a history & performed a physical examination today as documented above, and I have discussed anesthetic options & risks with the patient.

Temperature Monitoring
 Over the body warming device used intra-operatively to maintain normothermia
 Body temp \geq 36C (96.8F) recorded 30 min before care transfer or 15 min after care transfer
 If not achieved Medical Reason NOS

CRNA Signature	CRNA Identifier	In Time

Antibiotic
 Ordered Yes No
 Admin w/in 1 hour of surgery Yes No
 If not timely Medical Reason NOS
 IV PO
 Antibiotic _____ Time _____
 2nd Antibiotic _____ Time _____

My partner or I performed the following activities (initial)
 Present for induction
 Monitor at freq. intervals
 Immediately available
 Present for emergence
 Post Anesthesia Care

MDA Signature	MDA Identifier	In Time

Diagnosis

Surgeon	Identifier

Procedures

Anesthesiologist _____ Date _____ Time _____



Attending Anesthesiologist Pre-Anesthesia Exam & Evaluation						
Pre-op H&P By Dr. _____	Physical Exam					
NPO Since _____	Mental <input type="checkbox"/> Y <input type="checkbox"/> N Alert/Oriented	Airway	I II III IV			
Pertinent History 	Other _____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Neck Extends Well <input type="checkbox"/> Thyro-Mental Distance Adequate <input type="checkbox"/> Mouth Opening Adequate				
	Dentition _____ <input type="checkbox"/> Loose or Broken Teeth	Lungs <input type="checkbox"/> Clear to Auscultation				
	Heart <input type="checkbox"/> Regular Rate & Rhythm <input type="checkbox"/> Murmur	Other _____				
	Other _____	ASA	1	2	3	4
Past Surgeries <input type="checkbox"/> None	Anes Type	Problems / Complications	Labs/EKG/Echo/CXR <input type="checkbox"/> None			
			INR	K+	PT	GLU
			BUN	CREAT	PTT	HGB
Family Anesthesia History / Complications <input type="checkbox"/> None	<input type="checkbox"/> DNR <input type="checkbox"/> DNI		Discussion & Plan			
Anesthesiologist _____	Date _____	Time (Military) _____				

Post-Op Anesthesia Review		
<input type="checkbox"/> MAC <input type="checkbox"/> General <input type="checkbox"/> Regional: (Type) _____		
Respiratory Status	<input type="checkbox"/> Within normal limits	<input type="checkbox"/> Other: _____
Cardiovascular Status	<input type="checkbox"/> Within normal limits	<input type="checkbox"/> Other: _____
Hydration Status	<input type="checkbox"/> Within normal limits	<input type="checkbox"/> Other: _____
Mentation Status	<input type="checkbox"/> Baseline	<input type="checkbox"/> Other: _____
Pain Status	<input type="checkbox"/> Controlled	<input type="checkbox"/> Other: _____
Nausea/Vomiting	<input type="checkbox"/> Absent	<input type="checkbox"/> Other: _____
Temperature	<input type="checkbox"/> Normal for Pt	<input type="checkbox"/> Other: _____
Disposition: Patient is ready for discharge to: _____		
Comments: _____ _____ _____		
Signature _____	Date _____	Time _____

Order Date: _____

ALLERGIES: _____ DIAB: Y N WT: _____ kg

Check (✓) applicable blanks. Fill in numerical information where appropriate. Orders without a blank to fill are all active.

Admitting Physician: _____ Attending Physician: _____

Nursing Orders:

1. I / O: Insert foley catheter on hip or femur fractures.
2. Obtain surgical consent.
3. Follow Anesthesia Pre-op Orders (#17158).
4. Betadine scrub - 10 minutes - to surgical area if not casted or dressed.
5. Surgical shower before surgery.
6. Ted thigh high stockings to all laminectomy patients.
7. Ted thigh high stockings to unaffected leg on all fracture and hip injuries.

Diet: _____

IV's/Medications:

1. Ancef (cefazolin) 1 g IV pre-op. If allergic to cefazolin-type medications, use Vancomycin 1 g IV x 1 started 2 hours pre-op and infused over 60 minutes. If patient reports PCN allergy, call pharmacy for orders.
2. Patient has known MRSA history, colonization or infection, also give in addition to Ancef:
 - * Vancomycin 1 gm IV x 1 started 2 hours pre-op and infused over 60 minutes.
 - If patient is allergic, contact pharmacist for alternative antibiotic.
3. If patient develops a reaction to the antibiotic, stop infusion and give Benadryl (diphenhydramine) 50 mg IV x 1 and contact surgeon for further orders.

*****PEDIATRICS*****

1. Ancef (cefazolin) 25 mg/kg IV pre-op x 1, with max dose of 1 gram IV 30 min. pre-op. If allergic to cefazolin type medications, use Vancomycin 10 mg/kg IV x 1 with max dose of 1 gram IV x 1 started 2 hours pre-op and infused over 60 minutes. If patient reports PCN allergy, call pharmacy for orders. ** For Drs. Wyard, Friedland, Barnett, Meyer & Mair
2. Check with other surgeons day of surgery if pre-op antibiotic needed.

Diagnostics: (Labs, X-rays, etc.)

Labwork within 3 weeks:

1. For Hip and Femur fracture:

_____ PT/INR	_____ Type & Screen
_____ Hem. profile with diff.	_____ K+
_____ BMETA	_____ U/A; if positive for bacteria or protein, do UC
_____ CRP (Heeter only)	_____ ESR (Heeter only)
2. For Laminectomy And Shoulder surgery:
 - _____ Type & Screen

Medical Co-management:

Consult Hospitalist (for Ridgeview patients) for the following medical condition(s): _____

Discharge Planning:

On admission - initiate discharge plan with Social Worker assistance if patient on Medicare, has a hip fracture or is otherwise likely to require convalescent care services.

Physician's Signature: _____ Date: _____ Time: _____

ALL VERBAL ORDERS MUST BE SIGNED/DATED/TIMED BY AUTHORIZED PRACTITIONER WITHIN 24 HOURS

Ridgeview Medical Center
ORTHO ORDERS PRE-OP AA / INPATIENT

10/96, 8/10 (2)
17106



Order Date: _____

ALLERGIES: _____ DIAB: Y N WT: _____ kg

Check (✓) applicable blanks. Fill in numerical information where appropriate. Orders without a blank to fill are all active.

Admitting Physician: _____ Attending Physician: _____

Diagnosis: _____

Nursing Orders:

Vital signs: VS routine

O₂: Oxygen at 2-5 liters per nurse's discretion.

- I / O: 1. Call MD if urine output below 30 mL/hr x 4 hr. Discontinue when IV discontinued and voiding adequately.
- 2. If unable to void in 4-6 hrs or distended, straight cath prn. On 2nd cath, leave to straight drainage.

- Other: 1. **Laminectomy:** BRP or use commode day of surgery and up in room if stable; 1st post op day, mobilize and chair for meals, may elevate HOB 30°. Shower. Dressing change 1st post op day – cover with Tegaderm for showers only. Give patient copy of do's and don'ts. Use L.S. support when up.
- 2. **Shoulder Arthroscopy:** a. Activity: Wear immobilizer. Remove for hygiene. ROM to elbow tid.
- 3. Elevate operative area.
- 4. Check CMS affected extremity q2h.
- 5. Ice to operative area prn for pain and / or swelling x 24 hrs.
- 6. Shower / bath POD# _____
- 7. Pain pump discontinued POD# _____
- 8. Dressing change POD# _____
- 9. Incentive spirometer qid.
- 10. Plexi Pulse Foot Pumps.
- 11. Pneumococcal vaccine assessment. Influenza vaccine assessment (October 1 through March 1).

- Activity:** 1. Elevate (R) (L) Arm- _____ w/ immobilizer _____ w/sling _____ move elbow tid
Leg - _____ w/gatch _____ w/pillow
- 2. Activity: _____ Up Ad Lib _____ Up with assist _____ Up with walker/crutches _____ Sit in chair
_____ May flex to _____ ° _____ May recline _____ Pivot transfers _____ Lift
_____ Tilt to stand _____ Bedrest
- 3. Wt. Bearing: _____ Full _____ PWB _____ lbs _____ Non
- 4. Other: _____

Diet: _____ NPO _____ Advance _____ General _____ Special _____ Dietician recommendation

IV's/Medications:

Additional drug orders are to be written on the standard physician order sheet.

- 1. Complete Home Medication Reconciliation Orders sheet.
- 2. IV of D5 ½ NS@ _____ mL/hr with _____ mEq KCL/liter, to INT when taking po well.

Physician's Signature: _____ Date: _____ Time: _____

ALL VERBAL ORDERS MUST BE SIGNED/DATED/TIMED BY AUTHORIZED PRACTITIONER WITHIN 24 HOURS

Ridgeview Medical Center
ORTHO ORDERS POST-OP AA / INPATIENT

4/97, 3/11
17203



Ortho Orders Post-Op AA / Inpatient - continued

IV's/Medications: - continued

- 3. _____ Cefazolin 2 gm IV q8h x 2 doses post-op. If allergic to cephalosporins or severe PCN allergy, use Vancomycin 1 gm IV q12h X 1 dose post-op.
- 4. _____ Morphine IV q1h prn acute, severe pain or unable to tolerate oral intake: If pt is < 75 kg, begin with 2 mg. If pt is 75 kg & >, begin with 4 mg IV. May increase by 1 mg to a max of 10 mg per hour to achieve adequate pain relief. If no IV access, give Morphine 5 mg IM q4h prn acute, severe pain or unable to tolerate oral intake. Increase by 2.5 mg to a maximum of 15 mg in 4h to achieve adequate pain relief.
- OR
_____ Dilaudid (hydromorphone) 0.2 mg IV q1h prn acute, severe pain. May increase by 0.2 mg to a max of 2 mg per hour to achieve adequate relief.
- 5. _____ Toradol (ketorolac): If 65 yrs & > use 15 mg IM/IV q6h x24 h, then q6h prn muscle/bone pain. If < 65 yrs; use 30 mg IM/IV q6h x 24 hrs, then q6h prn pain. Do not administer if creatinine is > 1.4. Hold oral NSAID meds when on Toradol.
- 6. _____ Begin Oxycotin CR (oxycodone sustained release) _____ immediately **OR** _____ 8 hours **OR** _____ 24 hours post-op 10 mg po q12h; increase by 10 mg increments to 30 mg po q12h if pain relief not adequate.
- OR
_____ MS Contin (morphine sustained release) _____ immediately **OR** _____ 8 hours **OR** _____ 24 hours post-op 15 mg po q12h; may decrease time interval to q8h if breakthrough pain occurs; if pain relief still not adequate, increase by 15 mg increment to 45 mg po q8h.
- 7. _____ Norco-5 (hydrocodone 5 mg/APAP 325 mg) 1 tab po q4h PRN moderate pain. May increase to 2 tabs if ineffective. (limit APAP to 4,000 mg/24 hrs)
- OR
_____ Norco-10 (hydrocodone 10 mg/APAP 325 mg) 1 tab po q4h prn moderate pain. (limit APAP to 4,000 mg / 24h).
- 8. _____ Tylenol #3 (codeine 30 mg/APAP 300 mg) 1 tab po q4h PRN mild pain. May increase to 2 tabs if ineffective. (limit APAP to 4,000 mg/24 hrs)
- 9. _____ Tylenol (APAP) 325 mg po q4h PRN mild pain. May increase to 2 tabs if ineffective. (limit APAP to 4,000 mg/24 hrs)
- 10. _____ Vistaril (hydroxyzine) 25 mg po q4h prn spasm/anxiety/sleep. May increase by 25 mg to a max of 75 mg in 4 hrs if dose is ineffective. Dose may be given IM if unable to tolerate oral intake
- 11. _____ Zofran (ondansetron) 4 mg IV q6h prn for nausea. Not more than 2 doses.
- 12. _____ Ambien (zolpidem) 5 mg po qhs prn sleep. May repeat in 1 hour if ineffective.
- 13. _____ Senokot-S (Senna concentrate 8.6 mg / Docusate 50 mg) 1-2 tabs po bid. Hold if diarrhea.
- 14. **For CNS depression** (obtundation or respiratory rate less than 6 / minute):
Naloxone (Narcan) 0.1 mg IV. Notify ordering physician or physician on call STAT. May repeat naloxone every 3 minutes until findings are reversed. Continue to monitor closely.
- 15. May initiate Contingency Orders at nursing discretion (#17050).

Additional Orders:

Diagnostics: (Labs, X-rays, etc.)

X-ray AP & LAT R L _____ in PAR.

Treatments/Consultations/Referrals: (PT, OT, Nutrition, RT, etc.)

P.T.: _____ Progress Ambulation; provide ambulation equipment _____ ROM _____ other
_____ Walker _____ crutches _____ Quads _____ SLR

Discharge Planning:

- 1. Rx upon discharge: ___ Y ___ N
- 2. Schedule return clinic appointment at _____ on _____.

Physician's Signature: _____ Date: _____ Time: _____

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Ridgeview Medical Center

ORTHO ORDERS POST-OP AA / INPATIENT

4/97, 3/11
17203