

SISTERS OF CHARITY HOSPITAL • Buffalo, NY

 MERCY HOSPITAL • Buffalo, NY

Allergies & Sensitivities:
 No Known Allergies

 (Indicates automatic order. MD to draw line through orders to discontinue)

General OB Admission Orders

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Authorization is hereby given to dispense the generic/therapeutic equivalent unless otherwise indicated by the prescriber

DATE:	TIME:	PRESCRIBER ORDERS
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Level of Care:	<input type="checkbox"/> Urgent/Emergent	<input type="checkbox"/> Observation	<input type="checkbox"/> Ambulatory Surgery (ASU)	<input type="checkbox"/> Inpatient
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Transfer to :	<input type="checkbox"/> Medical- Surgical Unit	<input type="checkbox"/> Antepartum Floor	<input type="checkbox"/> _____
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Diagnosis: IUP at _____ weeks _____ days

Diagnosis:
 Vital signs as per protocol
 Vital signs every _____ hours X _____ hours

 Notify Physician if: BP systolic above 160 or below 90 or diastolic above 104, HR greater than 109, Temp greater than 100.4°F Urine output below 240 mL/8 hours

1. ACTIVITY:	<input type="checkbox"/> Strict Bedrest	<input type="checkbox"/> Bedrest with bathroom privileges	<input type="checkbox"/> OOB ad lib	<input type="checkbox"/> _____
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2. DIET:	<input type="checkbox"/> NPO	<input type="checkbox"/> Ice	<input type="checkbox"/> Clear Liquids	<input type="checkbox"/> Regular	<input type="checkbox"/> _____
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3. Nursing:

<input type="checkbox"/> Insert Foley Catheter	<input type="checkbox"/> Continuous Fetal Monitoring
<input type="checkbox"/> Strict Intake and Output	<input type="checkbox"/> Non-Stress Test every shift
<input type="checkbox"/> Seizure Precautions	

4. IV Fluids:
 Lactated Ringers 1000 mL at 100 mL/hour
 Keep total IV rate at _____ per hour

 _____ 1000 mL at _____ mL/hour

5. Medications:

6. Labs:

<input type="checkbox"/> Obtain pre-natal labs	<input type="checkbox"/> Urine Culture
<input type="checkbox"/> CBC with differential	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> CMP	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____	

7. Studies:

8. Fetal Evaluation
 Fetal sonogram in Fetal Testing Unit Reason: _____
 Maternal-Fetal Medicine consult : _____

9. Venous Thromboembolism Prophylaxis: (VTE)Potential Exclusions (Procedure entirely laparoscopic, surgery less than or equal to 30 min, stay equal to or less than 24 hours)**
 Sequential Compression Devices (recommended) until patient fully ambulatory
 Heparin 5,000 units subcutaneously every 8 hours start: _____

 Heparin 5,000 units subcutaneously every 12 hours start: _____

 Enoxaparin (Lovenox) 40 mg subcutaneously once daily start: _____

 No VTE Prophylaxis (reason: Not candidate Contraindicated List _____)

10.	<input type="checkbox"/> Neonatology consult
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11.	<input type="checkbox"/>
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12.	<input type="checkbox"/>
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13.	<input type="checkbox"/>
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14.	<input type="checkbox"/>
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Prescriber Signature: _____