



Patient Identification Information

- SISTERS OF CHARITY HOSPITAL • Buffalo, NY SISTERS OF CHARITY HOSPITAL ST JOSEPH Campus • Cheektowaga, NY
- KENMORE MERCY HOSPITAL • Kenmore, NY MERCY HOSPITAL • Buffalo, NY MERCY HOSPITAL Orchard Park division • Orchard Park, NY

Allergies & Sensitivities:

No Known Allergies

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

General Post-Op Orders

page 1 of 2

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

DATE:	TIME:	PRESCRIBER ORDERS
Level of Care: Admit to: <input type="checkbox"/> Observation <input type="checkbox"/> Ambulatory Surgery (ASU) <input type="checkbox"/> Inpatient Location: <input type="checkbox"/> Med Surg <input type="checkbox"/> Telemetry (<i>Indication</i>) _____ <input type="checkbox"/> Critical Care Unit Diagnosis: _____ Condition: <input type="checkbox"/> Stable <input type="checkbox"/> Fair <input type="checkbox"/> Serious <input type="checkbox"/> Critical <input type="checkbox"/> Vital signs as per protocol <input type="checkbox"/> Vital signs every ____ hours X ____ hours <input checked="" type="checkbox"/> Notify MD if: Systolic BP less than 90 or greater than 170, HR less than 50 or greater than 120, RR greater than 24, SPO2 less than 92%, Temp less than 95°F or greater than 101°F		
1. ACTIVITY: <input type="checkbox"/> Bedrest <input type="checkbox"/> Elevate head of bed ____ <input type="checkbox"/> Bedrest for ____ hours then OOB <input type="checkbox"/> Bedrest with Bathroom Privileges <input type="checkbox"/> OOB to chair <input type="checkbox"/> Ambulate <input type="checkbox"/> Activity as tolerated		
2. DIET: <input type="checkbox"/> NPO <input type="checkbox"/> Ice Chips <input type="checkbox"/> Clear liquid <input type="checkbox"/> Full liquid <input type="checkbox"/> Regular <input type="checkbox"/> Tube feedings _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Dietician consult		
3. NURSING ASSESSMENTS/INTERVENTIONS: <input type="checkbox"/> Cardiac monitor <input type="checkbox"/> Measure Intake/Output <input type="checkbox"/> Hourly urine output - If urine output less than ____ mL ____ hours Notify MD if less than 30 mL/hour <input type="checkbox"/> Foley catheter - routine catheter care <input type="checkbox"/> Discontinue on Post-op day # _____ <input type="checkbox"/> Incision Care: _____ <input type="checkbox"/> Dressing Care: _____ <input type="checkbox"/> Drain Care: Empty every _____ <input type="checkbox"/> NG to low intermittent suction <input type="checkbox"/> Measure every ____ hour(s) <input type="checkbox"/> Discontinue on Post-op day# ____ <input type="checkbox"/> CVP monitoring: _____ <input type="checkbox"/> Glucometers (Fingerstick glucose) every 6 hours or _____ (See Glycemic Control sheet)		
4. PATIENT EDUCATION <input type="checkbox"/> Pain Management <input type="checkbox"/> Coughing and Deep-breathing/Incentive Spirometry <input checked="" type="checkbox"/> Smoking Cessation <input type="checkbox"/> Wound Care: _____ <input type="checkbox"/> Other: _____		
5. RESPIRATORY: <input type="checkbox"/> Incentive Spirometry every 2 hours while awake <input type="checkbox"/> O2 at ____ Liters/minute by _____ Monitor O2 saturation and titrate oxygen per protocol		
6. IV INFUSION: <input type="checkbox"/> Lactated Ringers at _____ mL/hour <input type="checkbox"/> Dextrose 5% in Lactated Ringers at _____ mL/ hour <input type="checkbox"/> Dextrose 5% in Sodium Chloride 0.45% at _____ mL/hour <input type="checkbox"/> Dextrose 5% in Sodium Chloride 0.9% at _____ mL/hour <input type="checkbox"/> Sodium Chloride 0.45% at _____ mL/hour <input type="checkbox"/> Sodium Chloride 0.9% at _____ mL/hour <input type="checkbox"/> Other: _____		
Prescriber Signature: _____		



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page 2 of 2

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DATE:	TIME:	PRESCRIBER ORDERS
7. MEDICATIONS:		
Antibiotics (Prophylaxis = less than 24 hours post surgery): (see Perioperative Antibiotic Guide)		
<input type="checkbox"/> No prophylactic post operative antibiotics		
<input type="checkbox"/> Cefazolin (Ancef) 1gram IV every 8 hours X 3 doses Next dose based on pre-op dosage time: _____		
<input type="checkbox"/> Clindamycin (Cleocin) 600 mg IV every 8 hours X 3 doses [Penicillin/Cephalosporin allergy] Next dose based on pre-op dosage time: _____		
<input type="checkbox"/> Vancomycin 1 gram IV every 12 hours X 2 doses [Penicillin/Cephalosporin allergy or HX MRSA] Next dose based on pre-op dosage time: _____		
Antibiotics (Therapeutic = treatment of infection) – Please document source of infection		
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		
Nausea:		
<input type="checkbox"/> Metoclopramide (Reglan) 10 mg IV every 6 hours PRN for nausea/vomiting		
<input type="checkbox"/> Ondansetron (Zofran) 4 mg IV every 6 hours PRN for nausea/vomiting		
<input type="checkbox"/> Other: _____		
Pain:		
<input type="checkbox"/> Patient Controlled Analgesia - (See separate order form)		
<input type="checkbox"/> Epidural Pain Management - (See additional orders)		
<input type="checkbox"/> IV Analgesia: _____ mg every _____ hours PRN pain		
<input type="checkbox"/> IM Analgesia: _____ mg every _____ hours PRN pain		
<input type="checkbox"/> PO Analgesia: _____ mg every _____ hours PRN pain		
<input type="checkbox"/> Acetaminophen (Tylenol) 650 mg PO every 4 hours PRN for headache/temp over _____		
Other Medications: (see additional order sheet)		
<input type="checkbox"/> Beta Blocker: _____		
<input type="checkbox"/> GI Prophylaxis: _____		
<input type="checkbox"/> _____		
<input type="checkbox"/> _____		
8. LABORATORY:		
<input type="checkbox"/> CBC <input type="checkbox"/> BMP <input type="checkbox"/> CMP		
BLOOD TRANSFUSION: <input type="checkbox"/> Transfusion, _____ units of red blood cells(RBC), autologous		
<input type="checkbox"/> Transfusion, _____ units of red blood cells(RBC), homologous		
<input type="checkbox"/> _____		
9. Venous Thromboembolism Precautions: (VTE) (May Select More Than One)		
<input type="checkbox"/> Sequential Compression Device (SCD) until ambulatory		
<input type="checkbox"/> Heparin 5,000 units subcutaneously every 8 hours		
<input type="checkbox"/> Heparin 5,000 units subcutaneously every 12 hours		
<input type="checkbox"/> Enoxaparin (Lovenox) 40 mg subcutaneously daily		
<input type="checkbox"/> No VTE Prophylaxis (REASON) <input type="checkbox"/> Not a Candidate <input type="checkbox"/> Contraindicated <input type="checkbox"/> Other _____		
10. Referrals:		
<input type="checkbox"/> Medical Consult: _____		
<input type="checkbox"/> Care Management/Social Work		
<input type="checkbox"/> Enterostomal Therapist		
<input type="checkbox"/> Other _____		
Prescriber Signature: _____		