



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)

INTRAUTERINE FETAL DEMISE

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: Admit to: Inpatient

Location: Labor and Delivery

Dr. _____

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

Ultrasound to confirm fetal demise, gestational age

Activity: OOB as tolerated Bedrest for 2 hours after each vaginally inserted medication

Diet: NPO Clear Liquids Regular

IV Fluids:

IV _____ 1,000 mL at _____ mL/hour X _____ liters

Lactated Ringers 1,000 mL at _____ mL/hour X _____ liters

Induction Agents:

Misoprostol (Cytotec) 50 micrograms vaginally every _____ hours

Misoprostol (Cytotec) 200 micrograms vaginally every _____ hours

Misoprostol (Cytotec) 400 micrograms vaginally every _____ hours

Dinoprostone (Cervidil) 10 milligrams vaginal suppository once

Oxytocin (Pitocin) 15 units in 250 mL of Lactated Ringers IV at _____ milliunits / minute

Increase rate by _____ milliunits per minute Every 15 mins Every 30 mins

Medications

Metoclopramide (Reglan) 10 mg IV every 6 hours PRN nausea/vomiting

Ondansetron (Zofran) 4 mg IV every 6 hours PRN nausea/vomiting

Ondansetron (Zofran) 8 mg IV every 6 hours PRN nausea/vomiting

For Sleep: _____

For Pain: _____

<p>Labs</p> <p><input checked="" type="checkbox"/> CBC with diff, RPR</p> <p><input checked="" type="checkbox"/> Blood Type, Rh, Antibody Screen</p> <p><input checked="" type="checkbox"/> PT/PTT, Fibrinogen, FDP</p> <p><input checked="" type="checkbox"/> Hepatitis B Surface Antigen (if not documented in prenatal record)</p> <p><input type="checkbox"/> Urinalysis</p> <p><input type="checkbox"/> Urine C&S</p> <p>Cervical Cultures</p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Group B Strep</p>	<p>Generally Accepted Tests</p> <p><input type="checkbox"/> Urine Toxicology Screen</p> <p><input type="checkbox"/> Kleinhauer-Betke</p> <p><input type="checkbox"/> Parvovirus IgM, IgG</p> <p><input type="checkbox"/> Lupus anticoagulant antibody</p> <p><input type="checkbox"/> Anticardiolipin antibody</p> <p><input type="checkbox"/> Factor V Leiden mutation</p> <p><input type="checkbox"/> Prothrombin Gene Mutation</p> <p><input type="checkbox"/> Protein C Activity</p> <p><input type="checkbox"/> Protein S Activity</p> <p><input type="checkbox"/> Antithrombin III Activity</p> <p><input type="checkbox"/> MTHFR gene mutation</p> <p><input type="checkbox"/> TSH, free T4</p>	<p>Uncertain Utility</p> <p><input type="checkbox"/> TORCH Studies:</p> <p><input type="checkbox"/> Toxoplasmosis IgM, IgG</p> <p><input type="checkbox"/> Rubella IgM, IgG</p> <p><input type="checkbox"/> CMV titer IgM, IgG</p> <p><input type="checkbox"/> Herpes IgM, IgG</p> <p><input type="checkbox"/> Coxsackie Panel IgM, IgG</p> <p><input type="checkbox"/> Listeria IgM, IgG</p> <p><input type="checkbox"/> Placental Cultures: anaerobic, aerobic, ureaplasma, mycoplasma (between amnion/chorion membranes)</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p>
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<p>Pathology</p> <p><input type="checkbox"/> Consent for Full Fetal Autopsy</p> <p><input type="checkbox"/> Consent for External Fetal Autopsy</p>	<p><input type="checkbox"/> Placenta to Pathology</p> <p><input type="checkbox"/> Fetal Tissue for Genetic Studies</p> <p><input type="checkbox"/> Save Placenta sample for viral studies</p>
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<input type="checkbox"/> Social Work consult	<input type="checkbox"/> Bereavement Protocol
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<input type="checkbox"/>
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Prescriber Signature: _____