

OBSERVATION ORDERS

CHECK BOX TO ACTIVATE ORDER IF APPLICABLE

CROSS OUT NON-APPLICABLE ORDERS WITH SINGLE LINE

<p>ADMISSION INFORMATION</p> <p>Ht _____</p> <p>Wt _____</p>	<p>NOTE: Guidelines for Observation Care: Must meet all of the following, Unless stay has been pre-authorized:</p> <ul style="list-style-type: none"> ➢ Beyond the scope of usual outpatient care (post-op surgical or emergency patient) ➢ Expected to be short term (< 24 hrs) ➢ Appropriate for Observation care as indicated by at least 1 of the following: <ul style="list-style-type: none"> • Need for diagnostic evaluation (e.g. rule out MI) • Acute treatment & response evaluation needed (e.g. drug reaction) • Monitoring for an event (e.g. arrhythmia) or recovery (e.g. post op/drug ingestion) ➢ Consult with nursing supervisor or case manager regarding appropriate placement in observation <p>Place in OBSERVATION on: <input type="checkbox"/> Med/Surg <input type="checkbox"/> Tele (see Telemetry Standing Orders)</p> <p>With <input type="checkbox"/> HOSPITALIST SERVICE and/or <input type="checkbox"/> Dr. _____</p> <p>For: <input type="checkbox"/> Uncontrolled nausea/vomiting <input type="checkbox"/> Cardiovascular abnormalities (e.g. chest pain, hypertensive crisis)</p> <p><input type="checkbox"/> Excessive pain not controlled by oral analgesics <input type="checkbox"/> Neurologic abnormalities</p> <p><input type="checkbox"/> Severe SOB-hypoxia <input type="checkbox"/> Behavioral health issues</p> <p><input type="checkbox"/> Hemodynamically unstable <input type="checkbox"/> Post injury (e.g. head injury, snake bite, etc)</p> <p><input type="checkbox"/> Unexpected/excessive post op bleeding/drainage <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Abnormal mental status (e.g. post op sleepiness)</p> <p><input type="checkbox"/> Significant adverse reaction to proc. or treatment</p> <p>Surgery/Diagnosis: _____</p> <p>Secondary Diagnosis: _____</p> <p>Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Other: _____</p>
<p>REFERRALS</p>	<p><input type="checkbox"/> Discharge Planning <input type="checkbox"/> Financial Services <input type="checkbox"/> PT <input type="checkbox"/> OT</p>
<p>NURSING</p>	<p><input type="checkbox"/> Post-op VS every 15 mins until stable, then every 30 mins x 4, then every hr x 4</p> <p>OR VS: <input type="checkbox"/> every 4 hrs <input type="checkbox"/> every 8 hrs <input type="checkbox"/> Per Unit Protocol</p> <p><input type="checkbox"/> CSM checks _____ extremity every hour x 12, then every 4 hours</p> <p><input type="checkbox"/> I&O</p> <p>Dressing: _____</p> <p>Notify physician if: <input checked="" type="checkbox"/> HR < ____ or > ____ <input checked="" type="checkbox"/> SBP < ____ or > ____ <input checked="" type="checkbox"/> DBP > ____ <input checked="" type="checkbox"/> RR < ____ <input checked="" type="checkbox"/> Temp > ____</p> <p><input checked="" type="checkbox"/> SpO2 < ____ <input checked="" type="checkbox"/> Unusual wound drainage</p> <p>OR</p> <p><input type="checkbox"/> Notify physician if: HR <60 or >120 <input checked="" type="checkbox"/> SBP <80 or >160 <input checked="" type="checkbox"/> DBP >100 <input checked="" type="checkbox"/> RR <8 <input checked="" type="checkbox"/> Temp >101.5</p> <p><input checked="" type="checkbox"/> SpO2 <90% <input checked="" type="checkbox"/> Unusual wound drainage</p> <p><input type="checkbox"/> _____</p>
<p>LAB</p>	<p><input type="checkbox"/> _____ <input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____ <input type="checkbox"/> _____</p>
<p>X-RAY</p>	<p><input type="checkbox"/> _____ <input type="checkbox"/> _____</p>
<p>DIETARY</p>	<p><input type="checkbox"/> NPO until further orders <input type="checkbox"/> Sips and chips</p> <p><input type="checkbox"/> Progress diet as tolerated: <input checked="" type="checkbox"/> Clear liquids when bowel sounds present <input checked="" type="checkbox"/> Full liquids when tolerating clear liquids</p> <p><input checked="" type="checkbox"/> When tol. full liquids: <input type="checkbox"/> Regular <input type="checkbox"/> Cardiac <input type="checkbox"/> _____ Gm Sodium <input type="checkbox"/> _____ Calories ADA</p> <p><input type="checkbox"/> Encourage PO fluids</p>
<p>IV</p>	<p>IV: 1000 ml D5/.45 NaCl at _____ ml/hr OR <input type="checkbox"/> _____ at _____ ml/hr</p> <p><input type="checkbox"/> Saline lock. D/C IV or saline lock prior to discharge.</p>
<p>ANTIBIOTICS</p>	<p><input type="checkbox"/> _____</p>

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PAIN MEDICATIONS	<input type="checkbox"/> Ketoralac (Toradol) ____ mg IV every 6 hours x __ doses OR <input type="checkbox"/> ____ mg IV every 6 hours PRN x __ doses For IV pain control: <input type="checkbox"/> Morphine Sulfate ____ mg IV every 15 min PRN pain for mild pain (< 5/10) <input type="checkbox"/> Morphine Sulfate ____ mg IV every 15 min PRN pain for moderate pain (> 5/10) <input type="checkbox"/> Dilaudid ____ mg IV every hour PRN moderate pain (max = ____ mg in 4 hours) <input type="checkbox"/> Dilaudid ____ mg IV every hour PRN severe pain (max = ____ mg in 4 hours) <input type="checkbox"/> _____ <hr/> For PO pain control: <input type="checkbox"/> Percocet 5/325 1-2 tabs PO every 3 hrs PRN (1 tab for mild-mod pain < ⁵ / ₁₀ ; 2 tabs for mod-severe pain ≥ ⁵ / ₁₀) <input type="checkbox"/> Hydrocodone/Acetaminophen (Norco) 10/325mg 1 tab PO every 4 hrs PRN mild to moderate pain (< 5/10) <input type="checkbox"/> Hydrocodone/Acetaminophen (Norco) 10/325mg 2 tabs PO every 4 hrs PRN moderate to severe pain (≥ 5/10) <input type="checkbox"/> _____
NAUSEA VOMITING	<input type="checkbox"/> Dolasetron (Anzemet) 12.5 mg IV every 6 hours PRN nausea/vomiting, MR x 1 in 30 min <input type="checkbox"/> Ondansetron (Zofran) 4mg IV x 1 every 24 hours PRN nausea/vomiting <input type="checkbox"/> Promethazine (Phenergan) 25mg every 6 hrs PRN N/V PO (if tolerated) PR IM <input type="checkbox"/> Metoclopramide (Reglan) 10mg slow IV push over 2 minutes every 6 hrs PRN N/V <input type="checkbox"/> _____
ANXIETY	<input type="checkbox"/> Alprazolam (Xanax) 0.25 mg PO every 6 hours PRN anxiety or <input type="checkbox"/> Lorazepam (Ativan) _____ mg IV / PO (circle one) every _____ hrs PRN anxiety
SLEEP	<input type="checkbox"/> Temazepam (Restoril) PO HS PRN insomnia MR x1 in 1 hour <input type="checkbox"/> 7.5 mg PO (recommended for > 65 y.o.) <input type="checkbox"/> 15 mg PO (recommended for < 65 y.o.) OR <input type="checkbox"/> Zolpidem (Ambien) 5 mg PO HS PRN sleep MR X 1
ADDITIONAL MEDICATIONS OR ORDERS	<input type="checkbox"/> Tylenol 650mg PO every 4 hours PRN temp > 101 or mild pain (total Acetaminophen dose, including Norco and Percocet, not to exceed 4 gms/24 hours) <input type="checkbox"/> Maalox 30 ml PO every 2 hours PRN indigestion <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
DISCHARGE CRITERIA and Orders	<p>Must meet following discharge criteria BEFORE 23 hrs. If patient has not met criteria, call physician to determine inpatient status (order must be written BEFORE 23 hours)</p> <ul style="list-style-type: none"> • Hemodynamically stable (BP, heart rate, SpO2 within 20% of pre-op or usual state) • Nausea & vomiting minimal or absent • Able to take oral fluids (unless contraindicated) • No excess bleeding/drainage • Pain control documented: Score _____ • Alert & oriented or as usual/pre-op state • Steady gait & able to ambulate w/minimum dizziness (or returned to usual state) with: <input type="checkbox"/> walker <input type="checkbox"/> crutches • Ability to void or: <ul style="list-style-type: none"> ○ Instructions given for follow-up in 6-8 hrs ○ Urinary catheter in place, & instructions given for follow-up <p>Discharge Instructions</p> <ul style="list-style-type: none"> • Give written instructions to patient/responsible person. • Verify pre-arrangement for safe transport home and provide appropriate safety restraints for children as the law provides. • Provide additional resources to patients (durable medical equipment, pharmacy, etc.)
Physician Signature: _____ DATE _____ TIME _____ Transcriber Signature: _____ DATE _____ TIME _____	