



attach patient label here

Physician Orders ADULT Vascular Surgery Post Op Plan

[R] = will be ordered

T= Today; N = Now (date and time ordered)

Height: _____ cm Weight: _____ kg

Allergies:		<input type="checkbox"/> No known allergies
<input type="checkbox"/> Medication allergy(s): _____		
<input type="checkbox"/> Latex allergy <input type="checkbox"/> Other: _____		
Admission/Transfer/Discharge		
<input type="checkbox"/>	Return Pt to Room	T;N
<input type="checkbox"/>	Patient Status Change	T;N, Status _____, Reason for Visit _____, Reason for Change _____, Attending Physician _____ Bed _____ Type _____
<input type="checkbox"/>	Transfer Pt within current facility	T;N, Attending physician _____, Level of Care _____, Telemetry Type _____
<input type="checkbox"/>	Notify physician once	T;N, of room number on arrival to unit
Vital Signs		
<input type="checkbox"/>	Vital Signs	T;N, Routine Monitor and Record T,P,R,BP
Activity		
<input type="checkbox"/>	Keep Affected Leg Straight	T;N, Strict for duration of bedrest
<input type="checkbox"/>	Keep Flat	T;N, Strict for duration of bedrest
<input type="checkbox"/>	Bedrest	T;N, Strict for 6 hours
Food/Nutrition		
<input type="checkbox"/>	Regular Adult Diet	T;N,
<input type="checkbox"/>	Clear Liquid Diet	T; N
<input type="checkbox"/>	NPO	T;N
<input type="checkbox"/>	AHA Diet	T;N, 2 gm
<input type="checkbox"/>	Renal Diet Not On Dialysis	T;N,
<input type="checkbox"/>	Renal Diet On Dialysis	T;N,
<input type="checkbox"/>	Renal Diet On Dialysis	T;N, Adult (>18 years), 1800 Calorie, ADA
<input type="checkbox"/>	Consistent Carbohydrate Diet	T;N, Caloric Level: 1800 Calorie, Insulin: <input type="checkbox"/> None <input type="checkbox"/> Short Acting <input type="checkbox"/> Intermediate <input type="checkbox"/> Long Acting; Renal Patient: <input type="checkbox"/> No, <input type="checkbox"/> Yes, on dialysis, <input type="checkbox"/> Yes, not on dialysis
<input type="checkbox"/>	Combination Diet	T;N, (Choose up to 3) _____
Patient Care		
<input type="checkbox"/>	Advance Diet As Tolerated	T;N
<input type="checkbox"/>	Force Fluids	T;N
<input type="checkbox"/>	Sheath Site Monitoring	T;N, Right Femoral artery sheath-transduce to arterial line
<input type="checkbox"/>	Sheath Site Monitoring	T;N, Left Femoral artery sheath-transduce to arterial line
<input type="checkbox"/>	Sheath Remove	T;N, Special Instructions: May discontinue femoral sheath (____/____/____) if ACT less than ____ seconds, no groin hematoma, and no change in pedal pulses
<input type="checkbox"/>	Pedal Pulses Check	T;N, q1h monitor and record while sheath present or for 6 hours post procedure then q2h
<input type="checkbox"/>	Groin Check	T;N, Routine, q15 min x 4, then q30 min x 2, then q1h x 4 RIGHT post femoral angio
<input type="checkbox"/>	Groin Check	T;N, Routine, q15 min x 4, then q30 min x 2, then q1h x 4 LEFT post femoral angio
<input type="checkbox"/>	Groin Check	T;N, Routine, q1h(std), while sheath present
Continuous Infusions		
<input type="checkbox"/>	D5 1/2 NS	1,000 mL, IV, Routine, Start: T;N, ____ mL/hr
<input type="checkbox"/>	Sodium Chloride 0.9%	1,000 mL, IV, Routine, Start: T;N, ____ mL/hr
<input type="checkbox"/>	Sodium Chloride 0.45%	1,000 mL, IV, Routine, Start: T;N, ____ mL/hr



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Medications	
<input type="checkbox"/>	VTE Surgical Prophylaxis Plan
<input type="checkbox"/>	aspirin 81 mg, DR Tab, PO, once, STAT
<input type="checkbox"/>	aspirin 81 mg, DR Tab, PO, Qday, Routine, Start: T+1
<input type="checkbox"/>	aspirin 325 mg, DR Tab, PO, once, STAT,
<input type="checkbox"/>	aspirin 325 mg, DR Tab, PO, QDay, Routine, Start: T+1,
<input type="checkbox"/>	clopidogrel (Plavix) 300 mg, Tab, PO, once, STAT
<input type="checkbox"/>	clopidogrel (Plavix) 75 mg, Tab, PO, Qday, Routine, Start: T+1,
<input type="checkbox"/>	PCA- HYDROMORPHONE Protocol
<input type="checkbox"/>	OXYcodone 10 mg, Tab, PO, q4h PRN Pain, Severe (8-10)
<input type="checkbox"/>	Ondanestron 4 mg, injections, IVPush, q4h, PRN Nausea/Vomiting
<input type="checkbox"/>	Zolpidem 5 mg, Tab, PO, hs PRN Sleep
<input type="checkbox"/>	Laxative of Choice
	NOTE: Choose one cephalosporin AND vancomycin:
	NOTE: Give ceFAZolin 3G if patient weights greater than 120kg
<input type="checkbox"/>	ceFAZolin 2 g, IV Piggyback, IV Piggyback, q8h, Routine, (1 dose), Comment: time post
<input type="checkbox"/>	ceFAZolin 3 g, IV Piggyback, IV Piggyback, q8h, Routine, (1 dose), Comment: time post op dose 8 hours after preop dose (3G dose for weight greater than 120Kg)
	OR
<input type="checkbox"/>	Cefuroxime (Zinacef) 1.5 g, IV Piggyback, IV Piggyback, q12hr, routine x 1 dose. Comment: time post op dose 12 hours after last dose, not to exceed past 48 hours postop from OR stop time. (Same dose for all weights)
	AND
<input type="checkbox"/>	vancomycin 15mg/kg, IV Piggyback, IV Piggyback, once, Routine, (1 dose), Comment: time post op dose 12 hours after preop dose, not to exceed 48 hours Max 2G dose
	Note: If documented beta-lactam allergy, Give ONLY vancomycin:
<input type="checkbox"/>	vancomycin 15mg/kg, IV Piggyback, IV Piggyback, once, Routine, (1 dose), Comment: time post op dose 12 hours after preop dose. Max 2Gm dose
	Note: Select below to document contraindication
<input type="checkbox"/>	Indications-Continuing T;N, [] Suspected infect or [] actual infection
Laboratory	
<input type="checkbox"/>	CBC STAT, T;N, once, Type: Blood
<input type="checkbox"/>	BMP STAT, T;N, once, Type: Blood
<input type="checkbox"/>	PT STAT, T;N, once, Type: Blood
<input type="checkbox"/>	PTT STAT, T;N, once, Type: Blood
<input type="checkbox"/>	CBC Routine, T+1;0400, once, Type: Blood
<input type="checkbox"/>	BMP Routine, T+1;0400, once, Type: Blood
<input type="checkbox"/>	PT Routine, T+1;0400, once, Type: Blood
<input type="checkbox"/>	PTT Routine, T+1;0400, once, Type: Blood
Consults/Notifications	
<input type="checkbox"/>	Notify Resident-Continuing T;N, Notify: Vascular Resident 418-1004, any changes in pedal pulses, excessive bleeding from site, or hematoma formation

Date

Time

Physician's Signature

MD Number