**Physician’s Orders and Diet**

**PRE-OP ORDERS: ENT Pediatrics**

1. Admit for
2. CBC
3. NPO
4. Op Permit [ ] Remove tonsils  [ ] Remove adenoids
   - [ ] Place pressure equalizing tubes (PE TUBES) in eardrums
   - [ ] Go through nostrils to make openings into sinuses to allow for better drainage
   - [ ]  (Other Surgery)
5. Pre-Op orders by Anesthesia
6. [ ] Tetrahydrozoline (Tyzine) 0.05% 2 drops each nostril on call to OR
7. [ ] Oxymetazoline (Afrin) nasal spray 2 puffs each nostril on call to OR. Do not give to patient to take home
8. FOR PATIENTS WITH PE TUBES IN EARS:
   - [ ] Ofloxacin (Floxin) 0.3% on call to OR.
   - (send to OR with patient)

**Physician’s Signature** _____________________________
**Physician’s ID# _________ Date ________ Time _______

**Allergies:** ________________________________
## POST OP ORDERS:

1. Routine recovery

2. Please call physician if bleeding significantly or if bleeding persists

3. FOR PATIENTS WITH PE TUBES IN EARS:
   - Ofloxacin (Floxin) 0.3% ear drops, 5 drops to each ear twice daily

4. After return from Recovery Room, TPR and BP on return, q 1 hours x 2 or until stable, then q 4 hours

5. Encourage fluids, I & O, DO NOT BLOW NOSE

6. Offer ice collar, may use PRN for aches and pains

7. Elevate head of bed 30° - 75°

8. Change drip pad PRN when damp

9. Diet - cool clear liquids until no vomiting and then progress as rapidly as possible to
   - [ ] soft  [ ] regular diet

10. [ ] Acetaminophen (Tylenol) Elixir with Codeine __1 tsp __2 tsp q 4 hrs PRN pain, if allergic to codeine, use

11. [ ] Promethazine (Phenergan) suppository 0.5 mg / kg to maximum of 25 mg. (Round dose to either 6.25, 12.5, 18 or 25 mg) q 4 hours PRN nausea / vomiting.

12. D 5 1/2 NS with 20 mEq KCL _____ ml / hr

13. Discharge after meets discharge criteria

### IMMEDIATE POST OPERATIVE NOTE

(All Items Required)

**SURGEON:**

**ASSISTANTS:**

**PRE-OP DIAGNOSIS:**

**POST-OP DIAGNOSIS:**

**PROCEDURE/DESCRIPTION:**

**FINDINGS:**

**SPECIMENS REMOVED:**

- [ ] None  [ ] Other _______________________

**ESTIMATED BLOOD LOSS:**

**PHYSICIAN’S SIGNATURE**

**MD # ___________ Date _______ Time _______**

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