**Physician Orders ADULT**

**Title: Decompressive Laminectomy Post Op Plan**

[R] = will be ordered  
T= Today; N = Now (date and time ordered)

Height: ___________ cm  Weight: ___________ kg

**Allergies:**
- [ ] No known allergies
- [ ] Medication allergy(s):
- [ ] Latex allergy  [ ] Other:

<table>
<thead>
<tr>
<th>Uncategorized</th>
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</table>
| [ ] Initiate Powerplan Phase  
  T;N, Phase: Decompressive Laminectomy Post Op Phase  
  When to Initiate: [ ] |

<table>
<thead>
<tr>
<th>Admission/Transfer/Discharge</th>
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</table>
| [ ] Discharge When Meets Criteria  
  T;N, May discharge when: up without help, temperature not greater than 37.6 DegC, pain controlled by oral meds, feels confident for discharge, drains are out, taking liquids without problem, able to void. |
| [ ] Return Patient to Room  
  T;N |
| [ ] Transfer Patient  
  T;N |
| [ ] Patient Status Change  
  T;N, Reason for Visit: ________________  
  Attending Physician: ___________________  
  Status: Convert [ ] Inpatient to Observation, [ ] Observation to Outpt Ambulatory  
  [ ] Outpatient to inpatient, [ ] Outpatient to Observation Services,  
  [ ] Inpatient to Outpatient  
  Reason for Change: ____________________________________________________________________  
  Bed Type: ____________________________ |
| [ ] Notify physician once  
  T;N, of room number on arrival to unit |

<table>
<thead>
<tr>
<th>Vital Signs</th>
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</table>
| [ ] Vital Signs Per Unit Protocol  
  T;N, Monitor and Record T,P,R,BP |
| [ ] Vital Signs  
  T;N, Monitor and Record T,P,R,BP, q4h(std), For 24 hr |

<table>
<thead>
<tr>
<th>Activity</th>
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</table>
| [ ] Out Of Bed (Activity As Tolerated)  
  T+1; N, Up As Tolerated |
| [ ] Bedrest  
  T;N, Strict for 24 hrs |

<table>
<thead>
<tr>
<th>Food/Nutrition</th>
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</table>
| [ ] NPO  
  Start at: T;N |
| [ ] Clear Liquid Diet  
  Start at: T;N |
| [ ] Full Liquid Diet  
  Start at: T;N |
| [ ] Regular Adult Diet  
  Start at: T;N |
| [ ] 1800 Calorie ADA Diet  
  Start at: T;N |
| [ ] American Heart Association Diet (AHA Diet)  
  Start at: T;N, Age Group: ____________ |
| [ ] Sodium Control Diet (Diet Sodium Control)  
  Start at: T;N, Sodium Restriction: ____________  
  Age Group: ____________ |

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<tr>
<th>Patient Care</th>
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</table>
| [ ] Advance Diet As Tolerated  
  T;N, Advance as tolerated to regular unless special diet specified |
| [ ] Indwelling Urinary Catheter Care (Foley Care)  
  T;N, Routine |
| [ ] Catheterize In/Out  
  T;N, Routine, May I&O cath x one 6-8hrs postop. If have to repeat, insert Foley to straight drainage. |
| [ ] Wound Drain Care (Drain Care)  
  T;N, q-shift, Record hemovac drainage |
| [ ] Incentive Spirometry NSG  
  T;N, Routine, q2h-Awake |
**Title:** Decompressive Laminectomy Post Op Plan

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<table>
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<tr>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If patient has history of Peptic Ulcer or GI Bleed, Ketorolac is contraindicated.</strong></td>
</tr>
<tr>
<td>[ ] ketorolac 15 mg, INJECTION, IM, q6h, Routine, T; N (48 hr)</td>
</tr>
<tr>
<td>[ ] ondansetron 4 mg, INJECTION, IM, q6h, PRN Nausea, Routine, T; N</td>
</tr>
<tr>
<td>[ ] promethazine 25 mg, TAB, PO, q6h, PRN Nausea, Routine, T; N Comment: Use IV when PO not effective</td>
</tr>
<tr>
<td>[ ] acetaminophen 650 mg, TAB, PO, q4h, PRN Headache or Fever, Routine, T; N</td>
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<tr>
<td>[ ] OXYcodone 5 mg, TAB, PO, q3h, PRN Pain, Severe (8-10), Routine, T; N</td>
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<tr>
<td>[ ] acetaminophen-HYDROcodone 325 mg-5 mg 1 tab, TAB, PO, q4h, PRN Pain, Moderate (4-7), Routine, T; N</td>
</tr>
<tr>
<td>[ ] temazepam 7.5 mg, CAP, PO, hs, PRN Sleep, Routine, T; N</td>
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</tbody>
</table>

**Laxative of Choice Orders below:**
| [ ] magnesium hydroxide (Milk of Magnesia) 30mL, LIQ, PO, Daily, PRN Constipation, Routine, T; N |
| [ ] bisacodyl 5 mg, DR Tablet, PO, Daily, PRN Constipation, Routine, T; N |
| [ ] Al hydroxide/Mg hydroxide/simethicone (Maalox Max) 15 mL, Oral Susp, PO, q6h, PRN Gas, Routine, T; N |
| [ ] simethicone 160 mg, Chew tab, PO, q3h, PRN Gas, Routine, T; N |
| [ ] docusate 100 mg, CAP, PO, bid, Routine, T; N |

**Consults/Notifications**
| [ ] PT Initial Evaluation and Treatment T+1; 0800 |
| [ ] OT Initial Evaluation and Treatment T+1; 0800 |

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Date ___________________ Time ___________________ Physician’s Signature ___________________ MD Number ___________________