Physician Orders PEDIATRIC: LEB SDS General Post Op Plan

Initiate Orders Phase
Care Sets/Protocols/PowerPlans

☐ Initiate Powerplan Phase

Phase: SDS General Post Op Phase, When to Initiate:________________________

LEB SDS General Post Op Phase
Activity
☐ Activity As Tolerated
   Up Ad Lib

Food/Nutrition
☐ Clear Liquid Diet
   Start at: T;N

Patient Care
☐ Advance Diet As Tolerated
   Start clear liquids and advance to regular diet as tolerated.
☐ IV Discontinue When Tolerating PO
☐ IV Discontinue When Bag Complete
☐ Discharge Instructions
☐ Discharge When Meets Same Day Criteria

Continuous Infusion
☐ Sodium Chloride 0.9%
   1,000 mL, IV, Routine, mL/hr
☐ D5 1/2 NS KCl 20 mEq/L
   1,000 mL, IV, Routine, mL/hr
☐ Lactated Ringers Injection
   1,000 mL, IV, Routine, mL/hr

Medications
☐ +1 Hours acetaminophen
   10 mg/kg, Liq, PO, q4h, PRN Pain, Mild or Fever, Routine, Max Dose = 75 mg/kg/day up to 4g/day (DEF)*
   325 mg, Tab, PO, q4h, PRN Pain, Mild or Fever, Routine, Max Dose = 75 mg/kg/day up to 4g/day
☐ +1 Hours acetaminophen
   10 mg/kg, Supp, PR, q4h, PRN Pain, Mild or Fever, Routine, Max Dose = 75 mg/kg/day up to 4g/day
   Comments: May give PR if unable to give PO
☐ +1 Hours ibuprofen
   10 mg/kg, Oral Soln, PO, q8h, PRN Pain, Mild (1-3), Routine, Max dose = 800 mg, May use for pain unresponsive to acetaminophen
☐ +1 Hours acetaminophen-HYDROcodone 325 mg-7.5 mg/15 mL oral solution
   0.15 mg/kg, Liq, PO, q6h, PRN Pain, Moderate (4-7), Routine, (for 5 day ), (5 mL = 2.5 mg HYDROcodone), Max dose = 10mg
☐ +1 Hours acetaminophen-HYDROcodone 325 mg-5 mg oral tablet
   1 tab, Tab, PO, q4h, PRN Pain, Moderate (4-7), Routine, (for 5 day ), (1 tab = 5mg of hydrocodone), Max dose = 10mg

Laboratory
☐ CBC
   Routine, T;N, once, Type: Blood
☐ CMP
   Routine, T;N, once, Type: Blood

Diagnostic Tests
☐ Chest 1 VW
Physician Orders PEDIATRIC: LEB SDS General Post Op Plan

T: N, Routine, Portable

Consults/Notifications/Referrals

☐ Notify Resident-Continuing
☐ Notify Resident-Once
☐ Consult MD Group
   Reason for Consult:_________________ Group:_____________________
☐ Consult MD
   Consult Who:____________________ Reason for Consult:__________________
☐ Physical Therapy Ped Eval & Tx

________________________________________  ___________________________  ________________  ______________________
Date                                      Time                                     Physician’s Signature               MD Number

*Report Legend:
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase, see separate sheet
R-Required order