**PHYSICIAN'S ORDER**
(EXCLUDING IV Fluids and MEDICATIONS)

<table>
<thead>
<tr>
<th>DATE: ___________</th>
<th>TIME: ___________</th>
</tr>
</thead>
</table>

**Admit to:**
- ( ) ICU
- ( ) PCU
- ( ) PICU
- ( ) PEDIATRICS WARD
- ( ) TELEMETRY WARD
- ( ) MEDICAL SURGICAL WARD
- ( ) SURGICAL WARD

**Diagnosis:**

**Condition:**

**Code/Resuscitation Status:**
- ( ) Full Code
- ( ) DNR
- ( ) DNI

**Vitals:**
- ( ) Q2H
- ( ) Q4H
- ( ) Q6H
- ( ) Q8H

**Nursing:**
- ( ) Daily weight
- ( ) Strict intake and output
- ( ) Oxygen therapy
- ( ) Titrate O2 therapy to keep O2 sat >___%
- ( ) Incentive Spirometry q___ while awake
- ( ) Neurological checks q___
- ( ) Neurovascular checks q___

**Activity:**
- ( ) Bedrest
- ( ) Up ad Lib
- ( ) Up to chair
- ( ) Ambulate in hallway
- ( ) HOB 45 degrees
- ( ) Turn patient every 2 hrs.
- ( ) Others: ______________________

---

**INTRAVenous FLUID and MEDICATION ORDERS**

**DAllergy:**

**Intravenous Fluid:**
- ( ) 1000ml Lactated Ringer’s at _________ml/hr
- ( ) 1000ml 0.9% Normal Saline at _________ml/hr
- ( ) 1000ml 0.45% Normal Saline at _________ml/hr
- ( ) 1000ml D5 Water at _________ml/hr
- ( ) 1000ml D5 1/2 Normal Saline at _________ml/hr

**Analgesia:**
- ( ) Acetaminophen (Tylenol) 650mg P.O. every ____hrs PRN mild pain or for fever greater than:____F
- ( ) Acetaminophen (Tylenol) 650mg P.R. every ____hrs PRN mild pain or for fever greater than:____F
- ( ) Ibuprofen (Motrin) 400mg P.O. every ____hrs PRN mild pain or for fever greater than:____F
- ( ) Acetaminophen/Codeine (Tylenol#3) 300/30mg P.O. every ____hrs PRN pain greater than ___/10
- ( ) Hydrocodone/Acetaminophen (Norco) 5-325mg P.O. every ____hrs PRN pain greater than ___/10
- ( ) Oxycodone/Acetaminophen (Percocet) 5-325mg P.O. every ____hrs PRN pain greater than ___/10
- ( ) Ketorolac (Toradol) 30mg ml I.V. every ____hrs PRN pain greater than ___/10
- ( ) Fentanyl Patch _____mcg T.D. every ____hrs PRN pain greater than ___/10

---

**Summary/Blanket orders are unacceptable.**
**Medication orders must be complete.**
**PRN medication orders must include an indication.**
**Write legibly.**
**Rewrite orders upon transfer and/or post-operatively.**
**Date, time, and sign verbal & telephone orders within 48 hours.**

**DO NOT USE:**
- UMS
- IU
- MGSO4
- Q.D.
- Q.O.D.
- Trailing zero
- Lack of leading zero

---

**SURGERY ADMISSION ORDER**
Guam Memorial Hospital Authority
FORM# CPOE-034

---

**PATIENT ID LABEL**

---

**Physician Initial**
### PHYSICIAN'S ORDER
#### (EXCLUDING IV Fluids and MEDICATIONS)

**Diet/Nutrition:**
- ( ) Regular
- ( ) Soft/Mechanical Chopped/Ground
- ( ) Clear Liquid
- ( ) Full Liquid
- ( ) Diabetic diet ______ kcal
- ( ) Renal diet
- ( ) NPO
- ( ) NPO except medications
- ( ) NPO except medication and ice chips
- ( ) NPO except meds, ice chips and sips of liquid
- ( ) Tube feeding:_______ Goal rate:_______ml/hr
- ( ) Speech consult for swallow evaluation
- ( ) Dietitian consult
- ( ) Other:

**Standard Precautions:**
- ( ) Contact
- ( ) Special Contact
- ( ) Airborne
- ( ) Droplet
- ( ) Neutropenic
- ( ) Aspiration
- ( ) Other:

**Blood Glucose Monitoring:**
- ( ) AC & HS
- ( ) Q4H
- ( ) Q6H
- ( ) Every shift
- ( ) Other:

**Cultures:**
- ( ) Urine culture and sensitivity
- ( ) Blood culture x2 (peripheral draw)
- ( ) Sputum culture
- ( ) Stool culture
- ( ) Wound culture
- ( ) Other:

**Dressing change:**
- ( ) 4x4
- ( ) Abdpad
- ( ) Wet to dry Kerlix and 0.9%NSS
- ( ) Wet to dry Kerlix and Water
- ( ) Wet to dry Kerlix and Dakin’s Solution
- ( ) Xeroform
- ( ) Iodofrom
- ( ) Other:

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### INTRAVENOUS FLUID and MEDICATION ORDERS
#### ALLERGY:

**Analgesia cont:**
- ( ) Morphine _____mg I.V. every ____hrs PRN pain greater than ___/10
- ( ) Morphine sulfate tablet ___mg P.O. every____hrs PRN pain greater than ___/10
- ( ) Morphine oral solution ___mg P.O. every____hrs PRN pain greater than ___/10
- ( ) Hydromorphone _____mg I.V. every ____hrs PRN pain greater than ___/10
- ( ) Demerol ____mg I.V. every ____hrs PRN pain greater than ___/10
- ( ) Other:

**Anxiolytics:**
- ( ) Lorazepam (Ativan)____mg I.V. every____hrs PRN:
- ( ) Lorazepam (Ativan)____mg P.O. every____hrs PRN:
- ( ) Midazolam (Versed)____mg I.V. every____hrs PRN:
- ( ) Other:

**Antiemetics:**
- ( ) Ondansetron (Zofran) 4mg I.V. every:______hrs PRN nausea/vomiting
- ( ) Metoclopramide (Reglan) 10mg I.V. every:______hrs PRN nausea/vomiting
- ( ) Promethazine (Zofran) ___mg I.V. or I.M. every:______hrs PRN nausea/vomiting

- DO NOT USE:
  - U
  - MS
  - IU
  - MSO₄
  - Q.D.
  - MgSO₄
  - Q.O.D.
  - Trailing zero
  - Lack of leading zero

- **Physician’s Initial**
PHYSICIAN'S ORDER
(EXCLUDING IV Fluids and MEDICATIONS)

Frequency for dressing change:
( ) Daily
( ) BID
( ) PRN
( ) Per Shift
( ) Other:

Additional instructions for dressing change:
( ) Other:

Nursing communication orders:
( ) SBP more than ___ mmHg
( ) SBP less than ___ mmHg
( ) DBP more than ___ mmHg
( ) DBP less than ___ mmHg
( ) O2 saturation <90%
( ) HR > 120 bpm
( ) HR < 60 bpm
( ) Temperature greater than _____F
( ) Urine Output <0.5mL/kg/hr in 2 hours
( ) Other:

Lines, Drains, Airway:
( ) Insert and maintain foley to dependent drainage
( ) Insert and nasogastric tube to LIS
( ) Maintain on:______
( ) Insert and maintain orogastric tube to LIS
( ) Maintain on:______
( ) Maintain peripheral I.V. line/access
( ) I.V. access to saline Lock
( ) I.V. access to heparin Lock

Laboratory Service:
HEMATOLOGY:
Complete Blood Count with diff:(CBC)
( ) Stat
( ) Q6H
( ) Q12H
( ) Other:

Hemogram:(Hgb/Hct)
( ) Stat
( ) Q6H
( ) Q12H
( ) Other:

INTRAVERNIOUS FLUID and MEDICATION ORDERS

ALLERGY:

Antibiotics:
( ) Amoxicillin:____mg_____(route) every:
( ) Cefazolin:____gm_____(route) every:
( ) Augmentin:____mg_____(route) every:
( ) Bactrim D/S:____mg_____(route) every:
( ) Cefoxitin:____gm_____(route) every:
( ) Ceftriaxone:____gm_____(route) every:
( ) Clarithromycin:____mg____(route) every:
( ) Clindamycin:____mg_____(route) every:
( ) Doxycycline:____mg_____(route) every:
( ) Gentamicin:____mg_____(route) every:
( ) Cephalexin:____mg____(route) every:
( ) Levaquin:____mg____(route) every:
( ) Metronidazole:____mg____(route) every:
( ) Vancomycin:____gm____(route) every:
( ) Vancomycin per Pharmacy dose
( ) Piperacillin and Tazobactam (Zosyn)______gm
_______(route) every:
( ) Other:

DO NOT USE:
U   MS
IU  MSO4
Q.D. MgSO4
Q.O.D. Trailing zero
Lack of leading zero

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Guam Memorial Hospital Authority
FORM#CPOE-034

PATIENT ID LABEL
Physician Initial
PHYSICIAN'S ORDER
(EXCLUDING IV Fluids and MEDICATIONS)

CHEMISTRY:
Basic Metabolic Panel (Chem7)
( ) Stat  ( ) Daily
( ) Other:________________________

Comprehensive Metabolic Panel(Chem 20)
( ) Stat  ( ) Daily
( ) Other:________________________

Magnesium
( ) Stat  ( ) Daily
( ) Other:________________________

Phosphorus
( ) Stat  ( ) Daily
( ) Other:________________________

Amylase & Lipase
( ) Stat  ( ) Daily
( ) Other:________________________

Lactic Acid
( ) Stat  ( ) Daily
( ) Other:________________________

Prothrombin Time (PT)/INR
( ) Stat  ( ) Daily
( ) Q12H
( ) Other:________________________

Partial thromboplastin Time (APPT)
( ) Stat  ( ) Daily
( ) Q12H
( ) Other:________________________

Cardiac Labs:
( ) Troponin Q6H
( ) 12 Lead EKG Q:________________

Cardiac Enzyme Panel:
(CPKMB, MBRI Creatinine Phosphokinase)
( ) Stat  ( ) Daily
( ) Other:________________________

INTRA VENOUS FLUID and MEDICATION ORDERS

ALLERGY:

Bowel Care:
( ) Senna 8.6mg P.O./O.G.T./N.G.T. every:________
( ) Senna 17.2mg P.O./O.G.T./N.G.T. every:________
( ) Docusate (Colace) 100mg P.O./O.G.T./N.G.T. every:______
( ) Bisacodyl (Dulcolax) 10mg P.O./O.G.T./N.G.T. every:______
( ) Bisacodyl (Dulcolax) 10mg Suppository P.R. every:______ PRN constipation
( ) Lactulose 30ml P.O./O.G.T./N.G.T every:______ PRN constipation
( ) Polyethylene glycol 3350 (Miralax) 17g 1packet P.O./O.G.T./N.G.T  Daily PRN constipation
( ) Magnesium Hydroxide (Milk of Magnesia) 30ml P.O./O.G.T./N.G.T every:______ PRN constipation
( ) Sodium Biphosphatate sodium phosphate (Fleet Enema) 133ml PR every:______ PRN constipation
( ) Tap Water Enema PR every:______ PRN constipation (alternative to fleet enema in ESRD)
( ) Other:________________________

Topicals:
( ) Silvadene 1% Cream apply to wound/burn with dressing change
( ) Triple antibiotic ointment apply to wound with dressing change
( ) Other:________________________

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DO NOT USE:
U  MS
IU  MSO₄
Q.D.  MgSO₄
Q.O.D.  Trailing zero
Lack of leading zero

Physician’s Initial

SURGERY ADMISSION ORDER
Guam Memorial Hospital Authority
FORM# CPOE-034
**PHYSICIAN'S ORDER**  
(EXCLUDING IV Fluids and MEDICATIONS)

**Transfusion Service:**
- ( ) ABO Rh Type and Screen
- ( ) Cross match per _______ unit
- ( ) Transfuse PRBC _______ unit
- ( ) Transfuse Platelets _______ unit
- ( ) Transfuse FFP _______ unit
- ( ) Other: _____________________________

**Radiology:**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest X-Ray</td>
<td>( ) AP               ( ) PA</td>
</tr>
<tr>
<td></td>
<td>( ) LAT              ( ) Others: ______________________</td>
</tr>
<tr>
<td>Abdominal X-Ray</td>
<td>( ) AP ( ) Oblique ( ) Complete</td>
</tr>
<tr>
<td></td>
<td>( ) Acute Abdominal Series ( ) Others: ________________</td>
</tr>
<tr>
<td>Pelvis X-Ray</td>
<td>( ) AP ( ) PA</td>
</tr>
<tr>
<td></td>
<td>( ) LAT ( ) Others: ______________________</td>
</tr>
<tr>
<td>Extremity X-Ray</td>
<td>Indication: ____________________________</td>
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<tr>
<td>Part: __________________</td>
<td></td>
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<tr>
<td>View: __________________</td>
<td></td>
</tr>
<tr>
<td>Others: __________________</td>
<td></td>
</tr>
</tbody>
</table>

**Ultrasound:**

- ( ) Abdomen ( ) Pelvic
- ( ) Renal ( ) Breast
- ( ) Others: _____________________________

**INTRAVENTOUS FLUID and MEDICATION ORDERS**

**ALLERGY:**

- Vaccinations:
  - ( ) Tetanus/Td 0.5ml I.M. x1
  - ( ) Other: ____________________________________________

**Respiratory (non-ventilated patients)**

*(Check all that apply)*

- ( ) Albuterol 0.083% 2.5mg every: ___ INH nebulizer
- ( ) Ipratropium 0.02% 0.5mg every: ___INH nebulizer
- ( ) Other: ____________________________________________

**Stress Ulcer Prophylaxis:**

- ( ) Pantoprazole (Protonix) 40mg P.O. every: ______
- ( ) Pantoprazole (Protonix) 40mg I.V. every: ______
- ( ) Ranitidine (Zantac) 150mg P.O. every: ______
- ( ) Ranitidine (Zantac) 150mg P.O. per OGT/NGT every: ______
- ( ) Omeprazole (Prilosec) 20mg P.O. every: ______
- ( ) Other: ____________________________________________

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---

**SURGERY ADMISSION ORDER**

Guam Memorial Hospital Authority
FORM# CPOE-034
**PHYSICIAN’S ORDER**

(INCLUDING IV Fluids and MEDICATIONS)

**Doppler Ultrasound**
Indication: __________________________

Part: __________________________

Others: __________________________

**Computed Tomography Scan (CT-Scan)**

Head:
Indication: __________________________

( ) I.V. contrast ( ) Without contrast

Chest/Thoracic:
Indication: __________________________

( ) I.V. contrast ( ) Without contrast

Abdomen/Pelvis:
Indication: __________________________

( ) I.V. contrast only ( ) P.O. contrast only

( ) I.V. and P.O. contrast

( ) Without contrast

Cervical Spine:
Indication: __________________________

( ) I.V. contrast ( ) Without contrast

Thoracic Spine:
Indication: __________________________

( ) I.V. contrast ( ) Without contrast

Lumbar Spine:
Indication: __________________________

( ) I.V. contrast ( ) Without contrast

**Consultations:**

( ) Consult: __________________________

Indication: __________________________

Social Worker:

( ) Indication: __________________________

**INTRAVENTOUS FLUID and MEDICATION ORDERS**

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- IU  MSO₄
- Q.D.  MgSO₄
- Q.O.D.  Trailing zero
- Lack of leading zero

Physician Initial
<table>
<thead>
<tr>
<th>PHYSICIAN'S ORDER (EXCLUDING IV Fluids and MEDICATIONS)</th>
<th>INTRAVENOUS FLUID and MEDICATION ORDERS</th>
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</thead>
<tbody>
<tr>
<td>Occupational Therapy:</td>
<td>ALLERGY:</td>
</tr>
<tr>
<td>( ) Indication:____________________________________</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy:</td>
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<tr>
<td>( ) Indication:____________________________________</td>
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<tr>
<td>Dietary:</td>
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<tr>
<td>( ) Indication:____________________________________</td>
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<tr>
<td>Pharmacy:</td>
<td></td>
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<tr>
<td>( ) Indication:____________________________________</td>
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<tr>
<td>( ) Other:__________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICIAN**:

______________________________

(Print)

**Signature**:

______________________________

**Date**: ____/____/____ **Time**: ______

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**SURGERY ADMISSION ORDER**

Guam Memorial Hospital Authority


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