



PROVIDENCE HOSPITAL
6801 Airport Boulevard, Mobile AL 36608,
251/633-1000



PHYSICIAN'S ORDERS

DATE	HOUR	POSTERIOR LUMBAR FUSION POST OP ORDER	Baldwin Bone and Joint Dr. Canale
		<p>1. To Dr. Canale: <input type="checkbox"/> regular floor <input type="checkbox"/> ICU</p> <p>2. Diagnosis: DDD I-Spine</p> <p>3. Allergies: _____</p> <p>4. Condition: <input type="checkbox"/> Guarded <input type="checkbox"/> Serious</p> <p>5. Diet: Clear liquids only – advance diet in AM ONLY if patient has bowel sounds and appetite</p> <p>6. Activity:</p> <ul style="list-style-type: none"> • Incentive spirometer Q 1 H while awake. Encourage coughing and deep breathing. O₂ 2L NC x 24 H <input type="checkbox"/> Up in chair with assistance <input type="checkbox"/> Ambulate in hall with assistance <input type="checkbox"/> Today <input type="checkbox"/> in AM <p>7. <input type="checkbox"/> Physical Therapy: Gait training – FWB; OK to mobilize with assistance prior to arrival of back brace</p> <p>8. Vitals: Every 15 minutes until stable then per routine Neuromuscular checks every hour x 6 hours</p> <p>9. <input type="checkbox"/> Foley to bedside gravity x 48 hours. Physician to assess within 48 hours.</p> <p>10. Labs: Hemoglobin & Hematocrit every AM x 3 BMP in AM</p> <p>11. IVF: D5 1/2 NS at:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 30 mL per H <input type="checkbox"/> 125 mL per H <p>Decrease IV rate to 30 mL per H when tolerating liquids</p> <p>12. Medications:</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>PACU RN to complete. PACU RN initials: _____</p> <p>Incision closure time: Date: _____ Time: _____</p> <p>Next dose due Date: _____ Time: _____ <input type="checkbox"/> 1st Dose <input type="checkbox"/> 2nd Dose</p> </div> <p>Antibiotics:</p> <ul style="list-style-type: none"> <input type="checkbox"/> cefazolin (ANCEF) 1 g IV Q 6 H x 24 hours postop then discontinue <input type="checkbox"/> levofloxacin (LEVAQUIN) 500 mg PO x 1 dose Day of Surgery if tolerating oral intake <input type="checkbox"/> Resume other medications as indicated by the physician on the continue medication form <p>Pain:</p> <ul style="list-style-type: none"> <input type="checkbox"/> PCA as per separate PCA orders <input type="checkbox"/> morphine 2 mg to 4 mg IV Q 1 H for breakthrough pain <input type="checkbox"/> acetaminophen 325 mg with oxycodone 5 mg (PERCOCET 5) 1 to 2 tablets PO Q 4 H PRN breakthrough pain <input type="checkbox"/> acetaminophen 325 mg and hydrocodone 7.5 mg (NORCO 7.5) 1 to 2 tablets PO Q 4 H PRN moderate pain <p style="text-align: center;">Maximum acetaminophen dose is 4000 mg per 24 H</p> <ul style="list-style-type: none"> <input type="checkbox"/> promethazine (PHENERGAN) 6.25 mg to 12.5 mg IV Q 4 H PRN nausea <input type="checkbox"/> ondansetron (ZOFTRAN) 4 mg IV Q 6 H PRN vomiting <input type="checkbox"/> acetaminophen (TYLENOL) 650 mg PO Q 4 H PRN temperature greater than 103.9F <p>PRN:</p> <ul style="list-style-type: none"> milk of magnesia 30 mL PO daily PRN constipation 	





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		<p>13. Post-op Beta Blocker Therapy</p> <ul style="list-style-type: none"> <input type="checkbox"/> Not applicable <input type="checkbox"/> Continue beta blocker per medication reconciliation order <input type="checkbox"/> Beta Blocker Order: <ul style="list-style-type: none"> <input type="checkbox"/> Drug: _____ <input type="checkbox"/> Consult Dr. _____ or Hospitalist order beta blocker. <input type="checkbox"/> Will address beta blocker dosing on POD#1 based on hemodynamic status. <i>If beta blocker not administered on POD#1 or POD#2, contraindication must be documented.</i> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>PACU RN to complete PACU RN initials: _____</p> <p>Was patient on home beta blocker therapy prior to arrival <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, did the patient receive a beta blocker TODAY? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div> <p>Call Dr. Canale directly for a spine/orthopedic problems @ pgr 352-0046, cell 604-0111, home 626-9803</p> <p>Please call Dr. _____ for any other medical issues.</p> <p>Consult Dr. _____</p> <div style="margin-top: 20px;"> <p style="text-align: right;">_____ RN or PA Signature</p> <p style="text-align: right;">_____ Date</p> <p style="text-align: right;">_____ Time</p> </div> <div style="margin-top: 20px;"> <p style="text-align: right;">_____ Physician Signature</p> <p style="text-align: right;">_____ Date</p> <p style="text-align: right;">_____ Time</p> </div>	
		<p>Developed: April 2007 Revised: January 2011 Revised: December 2013</p>	

