(place patient label here)

Patient Name:_____

BENEFIS HEALTH SYSTEM
Benefis
HOSPITALS

PROVIDER ORDERS

Order Set Directions:
- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: _____

Allergies with reaction type:_____

Orthopedic Outpatient Lower Ext Post op **Version 1 2/2/2016**

- ☐ Up with Assistance as needed
- ☐ May ambulate
- ☐ Lower Ext Weight-bearing Status
  Left Leg: [ ] Non Weight Bearing [ ] Partial [ ] Toe Touch [ ] Heel Touch [ ] As tolerated
  Right Leg: [ ] Non Weight Bearing [ ] Partial [ ] Toe Touch [ ] Heel Touch [ ] As tolerated

Equipment and Activity Aids

- ☐ Knee immobilizer, hinged [ ] Apply/Maintain [ ] Maintain Only
  [ ] Left [ ] Right
  [ ] Advance 10 degrees every 2-3 hours up to 90 degrees as tolerated
  [ ] Keep immobilizer locked in full extension at all times
- ☐ Walking Boot [ ] Apply/Maintain [ ] Maintain Only
  Location: _____
  Type: _____
  Additional Instructions: _____
- ☐ Walking Shoe [ ] Apply/Maintain [ ] Maintain Only
  Location: _____
  Type: _____
  Additional Instructions: _____
- ☐ Walking Sandal [ ] Apply/Maintain [ ] Maintain Only
  Location: _____
  Type: _____
  Additional Instructions: _____
- ☐ Cryocuff
- ☐ Adaptive Equipment
  Type: [ ] Crutches [ ] Front Wheeled Walker [ ] Wheelchair [ ] Other _____
  Additional Instructions: _____

Nursing Orders

- ☑ Post-op vital signs (Q15 Min X4, Q30 Min X2, Q1H X 4, Q4H X 4) then per unit standard of care
- ☑ Monitor CSM (Color/Sensation/Movement) to affected extremity with Post Op Vital Signs (Q15 Min X4, Q30 Min X2, Q1H X 4, Q4H X 4)
- ☐ Apply ice pack to _____
- ☐ Elevate Affected Extremity
  Additional Instructions: _____
- ☐ Incision Care: _____
- ☐ Do not remove dressing
  Reinforce if needed; Keep dry
- ☐ Splint
  Do not remove; Keep dry
- ☐ Dressings Change
  Type: [ ] Dry Sterile [ ] Wet to Dry [ ] With Packing
  Begin: _____
  Frequency: [ ] Daily [ ] BID [ ] TID [ ] PRN
  Additional Instructions: _____

Respiratory

- ☑ Oxygen Delivery RN/RT to Determine Titrate to maintain Oxygen saturation greater than 90%

Initials_____

(place patient label here)

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Diet

☑ Clear Liquid Diet
☑ Advance diet as tolerated Goal diet: Regular
Additional Instructions:_____

IV Fluids - Maintenance

☑ Current IV @ _____ until taking PO well the KVO

Medications

Analgesics

acetaminophen 325 mg tablet (TYLENOL)
☐ 650 milligram orally every 4 hours as needed for mild-to-moderate pain
oxyCODONE-acetaminophen 5 mg-325 mg tab (PERCOCET)
☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain
oxyCODONE-acetaminophen 7.5 mg-325 mg tab (PERCOCET)
☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain
HYDROcodone-acetaminophen 5 mg-325 mg tab (NORCO)
☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain
HYDROcodone-acetaminophen 7.5 mg-325 mg tab (NORCO)
☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain
morphine
☐ 2 milligram intravenously every 4 hours as needed for severe pain , break through pain

Antiemetics

metoclopramide (REGLAN)
☐ 10 milligram orally or intravenously every 4 hours as needed for nausea/vomiting
ondansetron (ZOFRAN)
☐ 4 milligram intravenously every 4 hours as needed for nausea/vomiting

If MRSA/MSSA Positive SELECT:

mupirocin 2 % nasal ointment (BACTROBAN)
☐ 0.5 gram in each nostril 2 times a day for a total of 10 doses (Label for home use if patient discharged before completing all 10 doses)

Provider Signature:_____Date:_____Time:_____