(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:_____

Shoulder/Elbow Arthroscopy Post Op

Version 1 2/2/2016

General

☑ Diagnosis/Procedure: _____

Activity

☑ May ambulate ad lib
☐ Upper Ext Weight-bearing Status
Right: [ ] As Tolerated [ ] Non Weight Bearing [ ] Partial
Left: [ ] As Tolerated [ ] Non Weight Bearing [ ] Partial
☐ Range of Motion Restrictions
Location: _____
Type: [ ] Active [ ] Passive [ ] As Tolerated
Elevation Degrees: ____
Internal Rotation Degrees: _____
External Rotation Degrees: _____

Equipment and Activity Aids

☐ Sling [ ] Apply/Maintain [ ] Maintain Only
Location: _____
Type: _____
Additional Instructions: _____
☐ Sling Swathe [ ] Apply/Maintain [ ] Maintain Only
Location: _____
Type: _____
Additional Instructions: _____
☐ Immobilizer [ ] Apply/Maintain [ ] Maintain Only
Location: _____
Type: _____
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
☑ Incentive spirometry every 4 hours while awake x 48 hours
☑ Apply ice pack to _____
☐ Cryocuff
☑ Provide Arthroscopy Discharge Instructions
☑ Discharge Post-Op Criteria
Discharge criteria:
Patient is easily awakened by normal or softly spoken verbal communication;
Patient is oriented when awake as appropriate for age;
Vital signs within pre-procedure levels and cardiac rhythm stable;
There is no significant risk of losing protective reflexes;
Patent is able to maintain pre-procedure mobility;
Pain is controlled
Medication Reconciliation must be completed prior to discharge
Additional Criteria: _____

Diet

☑ Advance diet as tolerated Goal diet: Regular Additional Instructions:_____

Initials_____

(place patient label here)

Patient Name: _____

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IV Fluids - Maintenance

Dextrose 5% and 0.45% Sodium Chloride IV

- ☐ 125 milliliter/hour continuous intravenous infusion DC IV in PACU

☐ Continue OR IV fluid; DC IV in PACU

Medications

HYDROcodone-acetaminophen 5 mg-325 mg tab (NORCO)

- ☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain

oxyCODONE-acetaminophen 5 mg-325 mg tab (PERCOCET)

- ☐ 1-2 tablet orally every 4 hours as needed for moderate-to-severe pain

- For rotator repair, SLAP repair or stabilization SELECT:

cephalexin (KELFEX)

- ☐ 250 milligram orally every 8 hours x 24 hours

Provider Signature:_____Date:_____Time:_____