(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:_____

GENERAL OUTPATIENT POSTOP ORDERS Version 6 10/7/2015

1. VS's q 15 minutes until stable, q 1 H x 2, then q 4 H.
2. Up ad lib after recovery from anesthesia.
3. Clear liquids advance as tolerated.
4. Current IV @ _____ml/h until taking PO well, then KVO.

MEDICATIONS

- ☐ Percocet 5/325 (Oxycodone 5 mg/acetaminophen 325 mg) 1 or 2 tablets PO q 4 Hours PRN pain.
- ☐ Percocet 7.5/325 (Oxycodone 7.5 mg/acetaminophen 325 mg) 1 or 2 tablets PO q 4 Hours PRN pain.
- ☐ Tylenol 325mg (Acetaminophen) 1 or 2 tablets PO q 4 Hours PRN pain/headache
- ☐ Motrin 800mg (Ibuprofen) 1 tablet PO q 8 Hours PRN pain
- ☐ Norco 5/325 (Hydrocodone 5mg/acetaminophen 325mg) 1 or 2 tablets PO q 4 hours PRN pain
- ☐ Norco 7.5/325 (Hydrocodone 7.5 mg/acetaminophen 325mg) 1 or 2 tablets PO q 4 hours PRN pain
- ☐ Morphine 2mg IV push q4 hours PRN severe pain, break though pain
- ☐ Reglan 10 mg IV q 4 H PRN nausea.
- ☐ Zofran 4mg IV q 4 H PRN nausea
- ☑ If MRSA or MSSA positive: mupirocin (BACTROBAN) 2% nasal ointment 0.5 gram in each nostril 2 times a day for total of 10 total doses (Label for home use if patient is discharged before completing all 10 doses)

Call (Check appropriate request):
___ I will be on my pager and take my own calls for this patient;
___ Dr._____will be covering my patients after _____

Additional orders: _____
_____

Discharge orders: Discharge to _____ Follow up apt._____

Activity:_____ May Shower on:_____

Diet:_____

Wound care:_____

Dressings:_____

Expected amount of bleeding:_____

Additional orders: _____

Mastectomy Patients (Including Partial Mastectomy): Physical Therapy for evaluation of gait, posture, range of motion, altered center of gravity. Occupational therapy for evaluation of range of motion, functional status and lymphedema needs.

Discharge when criteria is met

- ☐ I have made no changes to the preadmission medication list. Contact the prescribing physician for questions.
- ☐ Additional medications as per prescriptions
- ☐ Does not need to void prior to discharge
- ☐ Discharge home, if unable to void return to ER

Provider Signature:_____Date:_____Time:_____