(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:_____

PRE-POST OPERATIVE- DR. OZOG 10/2009

PRE-OP

		(CIRCLE ONE)		
SPECIFIC PROCEDURE:	_____ UPPER LID BLEPHAROPLASTY	RT	LT	BILATERAL
	_____ ENTROPION REPAIR	RT	LT	BILATERAL
	_____ ECTROPION REPAIR	RT	LT	BILATERAL
	_____ LID LESION EXCISION	RT	LT	BILATERAL

Provider Signature:_____Date:_____Time:_____

POST-OP:

____ APPLY ICE COMPRESSES TO AREA X 48 HOURS
____ FOLLOW UP IN DOCTOR'S OFFICE IN 6 DAYS FOR SUTURE REMOVAL
____ MAXITROL UNG ½" TO WOUND TID
____ TOBRADEX UNG ½" TO WOUND TID
____ BACITRACIN UNG ½" TO WOUND TID

Provider Signature:_____Date:_____Time:_____