

CCU-2299-FRM REV 0 12.04.08	Conway Medical Center Conway, South Carolina PHYSICIAN'S ORDERS Gastrointestinal Bleed	Center Patient Admission Label Here
Another brand of drug identical in form and content may be dispensed unless checked. <input type="checkbox"/>		Drug Allergies:
Admit Status	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Observation	
Admit to:	<input type="checkbox"/> ICU <input type="checkbox"/> PCU <input type="checkbox"/> Telemetry <input type="checkbox"/> Other _____ Service of : _____	
Diagnosis		
Vital Signs	<input checked="" type="checkbox"/> Per Unit Protocol	
Activity	<input type="checkbox"/> Bed rest <input type="checkbox"/> with BRP	
Diet	<input type="checkbox"/> NPO <input type="checkbox"/> Clear liquids <input type="checkbox"/> Full liquids <input type="checkbox"/> Other _____	
IV Access/ IV Fluids/ Blood Products	<input type="checkbox"/> Peripheral line <input type="checkbox"/> Saline lock (2 nd IV site) <input type="checkbox"/> Consult Radiology for PICC line <input type="checkbox"/> Consult _____ for central venous access <input type="checkbox"/> IV fluids _____ ml/hr <input type="checkbox"/> Transfuse PRBC _____ units <input type="checkbox"/> Infuse FFP _____ units <input type="checkbox"/> Infuse platelets _____	
Respiratory Care	<input type="checkbox"/> O ₂ at _____ L/M via nasal cannula <input type="checkbox"/> Mechanical Ventilation Fi O ₂ _____ TV _____ Mode _____ Rate _____ Peep _____ PS _____ <input checked="" type="checkbox"/> Elevate HOB 30° to 45° unless contraindicated <input checked="" type="checkbox"/> Oral care Q 4 hrs and PRN with Q care, oral cleansing and suctioning system per protocol.	
Labs	<input type="checkbox"/> CBC <input type="checkbox"/> PT/PTT <input type="checkbox"/> CMP <input type="checkbox"/> Type and cross match _____ units PRBC <input type="checkbox"/> Hgb/Hct q _____ hrs. Notify MD for Hct ≤ _____.	
Diagnostic Studies	<input type="checkbox"/> Chest X-Ray <input type="checkbox"/> Portable <input type="checkbox"/> CT scan ABD <input type="checkbox"/> CT scan ABD / Pelvis <input type="checkbox"/> KUB/ upright ABD. <input type="checkbox"/> Other _____	
Consults	<input type="checkbox"/> GI _____ <input type="checkbox"/> Surgical _____	
Medications	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Protonix 40 mg IV <input type="checkbox"/> daily <input type="checkbox"/> BID <input type="checkbox"/> Protonix 80 mg IV plus continuous infusion at 8 mg/hr <input type="checkbox"/> Protonix 40 mg po <input type="checkbox"/> daily <input type="checkbox"/> BID <input type="checkbox"/> Sandostatin IV 25 mcg/hr 10 ml/hr (form 369) <input type="checkbox"/> Sandostatin IV 50 mcg/hr 20 ml/hr (form 369) <input type="checkbox"/> Antibiotics: _____ _____ </div> <div> <input type="checkbox"/> Miralax as follows: _____ _____ _____ <input type="checkbox"/> Other _____ _____ _____ </div> </div>	
<div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div> Physician Signature _____ </div> <div> Date ____/____/____ </div> <div> Time _____ </div> </div>		