



HH 1726572 ADM 1430705

HARLAKA

SUNIL

56 Y M 11S2

Dr NAGARAJAN GANESH

PHYSICIAN ORDER & MEDICATION ADMINISTRATION RECORD

Drug Allergies : NOT KNOWN

DAILY TREATMENT SHEET

DATE 21/11/19

INTI	PRINT NAME	INTI	PRINT NAME
RR	ROBERT R		

Sr. No.	DRUG / IV FLUIDS / Blood Product / Local Appl. To be filled in capitals. Write strength / Dose	ROUTE	FREQUENCY	Dr. Sign. Time	NURSES DRUG ADMINISTRATION	Remark / CANCELLATION Time / Sign.
1.	IVE : DNS 1 RL @ 800 cc/hr from 12:00 PM				TIME 12:30 PM SIGN RR.	
2.					TIME SIGN	
3.	PEGLEE 1 sachet in 1 litre of water				TIME 9:15 PM SIGN RR.	
4.					TIME SIGN	
5.	1 sachet				TIME SIGN	
6.	1 Sachet peglee in litre of water				TIME SIGN	
7.					TIME SIGN	
8.	PC. enema qm 6:00 AM				TIME 6:00 AM SIGN RR.	
9.					TIME SIGN	
10.					TIME SIGN	
11.					TIME SIGN	
12.					TIME SIGN	
13.					TIME SIGN	
14.					TIME SIGN	
15.					TIME SIGN	
16.					TIME SIGN	
17.					TIME SIGN	
18.					TIME SIGN	
19.					TIME SIGN	

Sr. No.	DRUG / IV FLUIDS / Blood Product / Local Appl. To be filled in capitals. Write strength / Dose	ROUTE	FREQUENCY	Dr. Sign. Time	NURSES DRUG ADMINISTRATION							Remark / CANCELLATION Time / Sign.
					TIME							
20.												
					SIGN							
21.												
					SIGN							
22.												
					SIGN							
23.												
					SIGN							
24.												
					SIGN							
25.												
					SIGN							

NON - DRUG ORDERS

Signature & Time

✓ OTCLPAC
 ✓ ilvlu consent
 ✓ NBM from 12:00 AM
 ✓ prep of part: NIPPLE to mid thigh including prep/premammary region (areolar areola by Dr. Radhe) private parts
 27/11/19 12am INVESTIGATION (S/N Radhe)
 LFT, K (VERBAL ORDER BY DR. RADHE S/N RADHE)
 ✓ OPBAC cross matching

Signature & Time

DISCHARGE ORDERS

Signature & Time

Expected Discharge on _____ (Date) before 11 am./ 3 pm.

Discharge Summary Prepared ☒ Y ☐ N / Dictated on Extn. _____

Discharge Instructions if any _____ in dinner.

DIET	<input type="checkbox"/> NBM	<input checked="" type="checkbox"/> CLEAR LIQUIDS	<input type="checkbox"/> NORMAL LIQUID	<input type="checkbox"/> SALT RESTRICTED
	<input type="checkbox"/> SALT FREE	<input type="checkbox"/> STERILE DIET	<input type="checkbox"/> FULL DIET	<input type="checkbox"/> DIABETIC
	<input type="checkbox"/> SOFT DIET			

Dietician Sign

Request Referral with reason

Urgent / Routine

Signature / Time