ITEMS WITH BOXES/PARENTHASES **MUST BE CHECKED** TO BE ORDERED. Orders that have been changed (additions, deletions, or strike outs) **must be initialed** by the ordering MD for the order to be valid.

PHYSICIAN'S ORDER (EXCLUDING IV Fluids and MEDICATIONS)

DATE: ____________ TIME: ______________

Labor & Delivery Scheduling Cesarean Section

Surgery is scheduled for:
Date: ______________ Time:____________
Pre-Op assessment at GMH on:
Date: ______________ Time:____________

No food or drink beginning midnight before your surgery.

At pre-op assessment:

- ❑ Register for pre-op at patient registration
- ❑ Diagnosis:
- ❑ Previous Cesarean Section
- ❑ Multiparity, desire for sterilization
- ❑ Breech presentation
- ❑ Gestational Diabetes
- ❑ Pregnancy Induced Hypertension
- ❑ Other:________________________
- ❑ Consent for Primary low transverse cesarean section
- ❑ Consent for Repeat Low transverse cesarean section
- ❑ Consent for bilateral tubal ligation
- ❑ Surgeon for consent: house for the day
- ❑ NPO after midnight before surgery
- ❑ Vital signs, weight, FHT
- ❑ CBC, urinalysis
- ❑ Type and crossmatch 2 units packed RBC
- ❑ Other:_____________________________

Date of admission:______________________
Upon admission:

- ❑ Admit to GMH, OB Ward
- ❑ NPO
- ❑ Accucheck blood sugar on admission
- ❑ Vital signs, weight, FHT
- ❑ Mini-Prep after anesthesia
- ❑ Insert Foley catheter after anesthesia
- ❑ Knee high sequential compression devices (SCD or ALPS) in Operating room
- ❑ Other:________________________________
  ____
  ____

IVF and MEDICATION ORDERS ONLY

IVF and MEDICATION ORDERS ONLY

IVF and MEDICATION ORDERS ONLY

IVF and MEDICATION ORDERS ONLY

INTRAVENOUS FLUID and MEDICATION ORDERS

ALLERGY:

- ❑ Start IV LR, bolus 500 ml, then run at 125 ml/hr until surgery
- ❑ Ancef 2 gram IV stat within one hour of incision
- ❑ Clindamycin 900 mg IV stat within one hour of incision if allergic to Penicillins or Cephalosporins
- ❑ Sodium Citrate 30 ml by mouth on call to the operating room
- ❑ Other:______________________________
  ____
  ____

Physician/CNM: _____________________________

Date: _____________ Time: ___________

PATIENT ID LABEL

- ✓ Summary/Blanket orders are unacceptable.
- ✓ Medication orders must be complete.
- ✓ PRN medication orders must include an indication.
- ✓ Write legibly.
- ✓ Rewrite orders upon transfer and/or post-operatively.
- ✓ Date, time, and sign verbal & telephone orders within 48 hours.

DO NOT USE:

U	MS
IU	MSO_4
Q.D.	$MgSO_4$
Q.O.D.	Trailing zero
Lack of leading zero	

Physician's Order Form- Scheduling Cesarean Section

Guam Memorial Hospital Authority
Revised 6/15 Approved: OB GYN 4/15, P&T 6/15, MEC 5/15, HIMC 6/15
FORM#______ Stock # ______