UMC Health System

OB/GYN PROVIDER TRIAGE PLAN
- Phase: Begin Immediately

Patient Label Here

PHYSICIAN ORDERS

Diagnosis ______________________________

Weight ______________________ **Allergies** ______________________

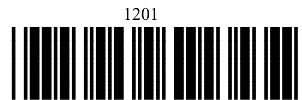
Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	Patient Care
	Vital Signs ☐ Per Unit Standards
	Strict Intake and Output ☐ Per Unit Standards
	Insert Peripheral Line
	POC Urinalysis Automated w/o Microscopy ☐ After each void ☐ One time
	Monitoring
	If greater than 24 weeks gestation: **Fetal Monitoring** ☐ Continuous EFM ☐ Continuous External Uterine Assessment by Toco only.
	If less than 24 week gestation: **Obtain Fetal Heart Tones via Doppler**
	Communication
	Notify Provider of VS Parameters ☐ Temp Greater Than 100.4, RR Greater Than 28, RR Less Than 12, SpO2 Less Than 95, SBP Greater Than 140, SBP Less Than 90, DBP Greater Than 90, DBP Less Than 50, HR Greater Than 120, HR Less Than 60
	Dietary
	NPO Diet ☐ NPO ☐ NPO, Except Meds ☐ NPO, Except Ice Chips ☐ NPO, Except Meds, Except Ice Chips
	Oral Diet ☐ Regular Diet ☐ Clear Liquid Diet ☐ Carbohydrate Controlled (1600 calories) Diet ☐ Carbohydrate Controlled (2000 calories) Diet
	IV Solutions
	LR (Lactated Ringer's) ☐ IV, 75 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 100 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 125 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 150 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order.

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: ______________________ Date ____________ Time ____________

Physician Signature: ______________________ **Date** ____________ **Time** ____________



UMC Health System OB/GYN PROVIDER TRIAGE PLAN - Phase: Begin Immediately	Patient Label Here

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	NS (Normal Saline) ☐ IV, 75 mL/hr ☐ IV, 100 mL/hr ☐ IV, 125 mL/hr ☐ IV, 150 mL/hr
	1/2 NS ☐ IV, 75 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 100 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 125 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 150 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order.
	D5 1/2 NS ☐ IV, 75 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 100 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 125 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 150 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order.
	D5LR ☐ IV, 75 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 100 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 125 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order. ☐ IV, 150 mL/hr Ordered via OB/GYN Triage Plan SDO - Dr. E. Yeomans MD Standing Delegated Order.
	Laboratory
	CBC ☐ Routine, T;N
	CBC with Differential ☐ Routine, T;N
	Basic Metabolic Panel ☐ Routine, T;N
	Comprehensive Metabolic Panel ☐ Routine, T;N
	Prothrombin Time with INR ☐ Routine, T;N
	PTT ☐ Routine, T;N

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Order Taken by Signature: ____________________ Date ____________ Time ____________

Physician Signature: ____________________ **Date** ____________ **Time** ____________

UMC Health System

OB/GYN PROVIDER TRIAGE PLAN
- Phase: Begin Immediately

Patient Label Here

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	ALT Routine, T;N ☐
	AST ☐ Routine, T;N
	LDH ☐ Routine, T;N
	Uric Acid Level ☐ Routine, T;N
	HIV Screen ☐ Routine, T;N
	Fibrinogen Level ☐ Routine, T;N
	Kleihauer Betke Stain ☐ Routine, T;N
	Fetal Fibronectin ☐ Routine, T;N
	Syphilis Screen ☐ Routine, T;N
	Urine Random Drug Screen ☐ Urine, Routine, T;N
	Urinalysis ☐ Urine, Routine, T;N
	Urine 24hr Creatinine ☐ Routine, T;N
	Urine 24hr Protein ☐ Routine, T;N
	Culture Urine
	Neisseria gonorrhoeae by PCR
	Chlamydia trachomatis by PCR
	Culture Genital Beta Strep B
	Culture Throat Beta Strep A
	HSV 1.2 by PCR
	SARS-CoV-2 / Flu / RSV by PCR
	Wet Prep Exam
	Herpes Simplex Virus 1 and 2 IgG (HSV 1 and 2 IgG)
	...Additional Orders

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Order Taken by Signature: ____________________ Date ____________ Time ____________

Physician Signature: ____________________ **Date** ____________ **Time** ____________

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UMC Health System OB/GYN PROVIDER TRIAGE PLAN - Phase: Discharge Orders	**Patient Label Here**

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS	
	Admit/Discharge/Transfer	
	General	
	Discharge Patient	
	Discharge Condition ☐ Discharge Condition: Stable ☐ Discharge Condition: Fair	☐ Discharge Condition: Improved
	Discharge Disposition ☐ Discharge To: Home ☐ Discharge To: SNF ☐ Discharge To: Hospice Home ☐ Discharge To: TDCJ or any other jail	☐ Discharge To: Home with Home Health ☐ Discharge To: Nursing Home - Intermediate Care ☐ Discharge To: Long term care ☐ Discharge To: Rehab
	Discharge Instructions ☐ Discharge Instructions: Keep all follow-up appointments | Take all medications as prescribed	
	Diet	
	Discharge Diet ☐ Diet: Regular ☐ Diet: AHA ☐ Diet: Renal	☐ Diet: ADA ☐ Diet: Low sodium (Less than 2 grams) ☐ Diet: Resume pre-hospital diet
	Activity	
	Discharge Activity/Activity Precautions ☐ Activity: As tolerated | No restrictions	
	Discharge Lifting Instructions ☐ Restricted Amount: 8-10 Pounds	
	Follow Up	
	Discharge Follow-up Appointment	
	Discharge Follow-up Appointment	
	Discharge Follow-up Lab	
	Discharge Follow-up Radiology	
	Discharge Follow-up Diagnostic Procedure (Discharge Follow-up Diagnostic Procedures)	

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Order Taken by Signature: ______________________________ Date ______________ Time ______________

Physician Signature: ______________________________ **Date** ______________ **Time** ______________

UMC Health System OB/GYN PROVIDER TRIAGE PLAN - Phase: BB TYPE AND SCREEN PLAN	Patient Label Here

PHYSICIAN ORDERS

Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.

ORDER	ORDER DETAILS
	Laboratory
	BB Blood Type (ABO/Rh)
	BB Antibody Screen

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: ______________________ Date ____________ Time ____________

Physician Signature: ______________________ **Date** ____________ **Time** ____________

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