

OUTPATIENT ULTRASOUND GUIDED OOCYTE
RETRIEVAL PLAN
- Phase: Day of Procedure Pre-Op Orders

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

Admit/Discharge/Transfer

Request for Outpatient Services

- Location: Outpatient Surgery, Admitting Dx/Reason: Infertility, Procedure: Oocyte Retrieval, ATTENDING Physician: Jennifer Phy D.O.
- Location: Outpatient Surgery, Admitting Dx/Reason: Infertility, Procedure: Oocyte Retrieval, ATTENDING Physician: Dr. Huang

Patient Care

Patient Activity

- Bedrest | Bathroom Privileges

Insert Peripheral Line

Communication

Code Status

- Code Status: Full Code

Misc Patient Care Order

Misc Patient Care Order

Dietary

Outpatient Diet

- NPO

IV Solutions

NS

- IV, 75 mL/hr
- IV, 100 mL/hr
- IV, 125 mL/hr
- IV, 150 mL/hr

Medications

Medication sentences are per dose. You will need to calculate a total daily dose if needed.

ceFAZolin

- 1 g, IVPush, inj, ONE TIME, Pre-OP/Post-Op Prophylaxis
Send Med to Family Care Unit
Reconstitute with 10 mL of Sterile Water or NS
Administer IV Push over 3 minutes
- 2 g, IVPush, inj, ONE TIME, Pre-OP/Post-Op Prophylaxis
Send Med to Family Care Unit
Reconstitute each vial with 10 mL of Sterile Water or NS
Administer IV Push over 3-5 minutes

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Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ Date _____ Time _____



UMC Health System

Patient Label Here

OUTPATIENT ULTRASOUND GUIDED OOCYTE
RETRIEVAL PLAN
- Phase: Day of Procedure Pre-Op Orders

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

Additional Medication

If additional medications are needed, complete the following "misc medication" order to allow pharmacy to enter into PowerChart

misc medication

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Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ Date _____ Time _____



<p>UMC Health System</p> <p>OUTPATIENT ULTRASOUND GUIDED OOCYTE RETRIEVAL PLAN - Phase: Discharge Orders</p>	<p>Patient Label Here</p>
<p>PHYSICIAN ORDERS</p>	
<p>Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.</p>	
ORDER	ORDER DETAILS
<p>Admit/Discharge/Transfer</p>	
<p>General</p>	
	<p>Discharge Patient <input type="checkbox"/> Discharge Time: T;N</p>
	<p>Discharge Condition <input type="checkbox"/> Discharge Condition: Stable <input style="margin-left: 200px;" type="checkbox"/> Discharge Condition: Improved <input type="checkbox"/> Discharge Condition: Fair</p>
	<p>Discharge Disposition <input type="checkbox"/> Discharge To: Home</p>
	<p>Discharge Instructions <input type="checkbox"/> Discharge Instructions: Take all medications as prescribed Keep all follow-up appointments</p>
<p>Diet</p>	
	<p>Discharge Diet <input type="checkbox"/> Diet: Resume pre-hospital diet</p>
<p>Activity</p>	
	<p>Discharge Activity/Activity Precautions <input type="checkbox"/> Activity: As tolerated No restrictions</p>

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Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ Date _____ Time _____



<p>UMC Health System</p> <p>OUTPATIENT ULTRASOUND GUIDED OOCYTE RETRIEVAL PLAN - Phase: OPS Post-Op Orders</p>	<p>Patient Label Here</p>
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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
	Patient Care
	Vital Signs <input type="checkbox"/> Per Unit Standards
	Convert IV to INT <input type="checkbox"/> when tolerating PO intake.
	Communication
	Code Status <input type="checkbox"/> Code Status: Full Code
	Notify Nurse (DO NOT USE FOR MEDS) <input type="checkbox"/> Discharge patient after voiding, has good pain control, and tolerates PO well.
	Notify Provider (Misc) <input type="checkbox"/> Notify Dr. Jennifer Phy, Reason: Questions or concerns, Office - 743-4256 <input type="checkbox"/> Notify Dr. Jaou-Chen Huang, Reason: Questions or concerns, Office - 743-4256
	Dietary
	Outpatient Diet <input type="checkbox"/> Clear Liq. Advance to Pre-Hospital Diet
	Medications
	Medication sentences are per dose. You will need to calculate a total daily dose if needed.
	Pain Management
	acetaminophen <input type="checkbox"/> 500 mg, PO, tab, q4h, PRN pain-mild (scale 1-3) Do not exceed 4000 mg of acetaminophen per day from all sources. <input type="checkbox"/> 1,000 mg, PO, tab, q6h, PRN pain-mild (scale 1-3) Do not exceed 4000 mg of acetaminophen per day from all sources.
	Anti-pyretics
	acetaminophen <input type="checkbox"/> 500 mg, PO, tab, q4h, PRN fever Do not exceed 4000 mg of acetaminophen per day from all sources. <input type="checkbox"/> 1,000 mg, PO, tab, q6h, PRN fever Do not exceed 4000 mg of acetaminophen per day from all sources.

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Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ Date _____ Time _____



OUTPATIENT ULTRASOUND GUIDED OOCYTE
RETRIEVAL PLAN
- Phase: PACU Post-Op Orders

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
Patient Care	
	Vital Signs <input type="checkbox"/> Per Unit Standards
Communication	
	Notify Provider of VS Parameters <input type="checkbox"/> SBP Greater Than 110, SBP Less Than 60, DBP Greater Than 100, DBP Less Than 50, HR Greater Than 110, HR Less Than 60, Notify Ordering Provider
Misc Patient Care Order	
Medications	
Medication sentences are per dose. You will need to calculate a total daily dose if needed.	
Pain Management	
	acetaminophen <input type="checkbox"/> 500 mg, PO, tab, ONE TIME, PRN pain-mild (scale 1-3) ***To be administered in PACU only*** <input type="checkbox"/> 1,000 mg, PO, tab, ONE TIME, PRN pain-mild (scale 1-3) ***To be administered in PACU only***
	HYDROcodone-acetaminophen (HYDROcodone-acetaminophen 7.5 mg-325 mg oral tablet) <input type="checkbox"/> 1 tab, PO, tab, ONE TIME, PRN pain-moderate (scale 4-6) ***To be administered in PACU only*** <input type="checkbox"/> 2 tab, PO, tab, ONE TIME, PRN pain-moderate (scale 4-6) ***To be administered in PACU only***
	ketorolac <input type="checkbox"/> 15 mg, IVPush, inj, ONE TIME, PRN pain-moderate (scale 4-6) ***To be administered in PACU only***
	HYDROmorphine <input type="checkbox"/> 1 mg, IVPush, inj, ONE TIME, PRN pain-severe (scale 7-10) ***To be administered in PACU only***
Antiemetics	
	ondansetron <input type="checkbox"/> 4 mg, IVPush, inj, ONE TIME ***To be administered in PACU only*** <input type="checkbox"/> 8 mg, IVPush, inj, ONE TIME ***To be administered in PACU only***

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Order Taken by Signature: _____ Date _____ Time _____

Physician Signature: _____ Date _____ Time _____

