

UMC Health System SHORT TERM OXYGEN THERAPY PLAN	Patient Label Here
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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

Respiratory	
	Oxygen Therapy Protocol
	Continuous Pulse Oximetry
	Oxygen Spot Check <input type="checkbox"/> q12h, As needed for oxygen Titration.
	Respiratory Care Plan Guidelines
	Oxygen Therapy <input type="checkbox"/> Keep sats greater than: 93%

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TO Read Back Scanned Powerchart Scanned PharmScan
 Order Taken by Signature: _____ Date _____ Time _____
 Physician Signature: _____ Date _____ Time _____