



<p style="text-align: center;">THE UNIVERSITY OF KANSAS HOSPITAL KUMED 3901 Rainbow Boulevard Kansas City, Kansas 66160</p>	<p>Do not write in this box</p>  DT0017	PATIENT LABEL
PHYSICIAN'S ORDER FORM		

DATE & TIME	#	ORDERS GASTRIC BYPASS ORDERS
		Reference:
	1.	Admit to Unit _____, Attending _____, Pager _____
	2.	Diagnosis: Morbid obesity, S/P Gastric Bypass
	3.	Condition:
	4.	ALLERGIES:
	5.	Vital signs: Every _____ hours
	6.	Diet : <input type="checkbox"/> NPO <input type="checkbox"/> NPO except ice chips <input type="checkbox"/> _____
	7.	Activity: <input type="checkbox"/> Bedrest <input type="checkbox"/> Out of Bed <input type="checkbox"/> Ambulate with assistance in halls starting this evening
	8.	Foley catheter to Dependent Drainage
	9.	Jackson Pratt drains to Bulb Suction
	10.	Strict I/O's every shift
	11.	Cough, deep breathing, and Incentive Spirometry (check box): <input type="checkbox"/> q _____ hours <input type="checkbox"/> q _____ hours while awake
	12.	Ventilator:
	13.	O ₂ per nasal cannula at _____ Liters/minute
	14.	Pulse oximetry (check box): <input type="checkbox"/> q 4 hours <input type="checkbox"/> continuous
	15.	Transduce CVP q 4 hours
	16.	Sequential Compression stockings on at all times when in bed.
	17.	Notify Physician for any of the following: SBP < _____ or > _____ HR < _____ or > _____ Temperature > 38.5 Urine output < _____ mL/hr x _____ O ₂ saturation < 92% < _____ mL in 8 hours
	18.	PACU Labs: CBC with diff, Chem 7, Magnesium, Phosphorus, ABG, portable Chest Xray
	19.	Labs: CBC with diff, Chem 7, Magnesium, Phosphorus <input type="checkbox"/> q am <input type="checkbox"/> a.m. of ___/___/___
	20.	Gastrograffin small bowel series in AM ___/___/___; may premedicate with <input type="checkbox"/> Ondansetron _____ mg IV x1 <input type="checkbox"/> _____ IV x 1 for pain
	21.	IV fluids:



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	22.	Medications: <input type="checkbox"/> Enoxaparin _____ mg subcutaneous q _____ hours <input type="checkbox"/> Metoclopramide _____ mg IV q _____ hours <input type="checkbox"/> Famotidine 20 mg IV q _____ hours <input type="checkbox"/> Ondansetron 4mg IV q _____ hours prn nausea/vomiting <input type="checkbox"/> Albuterol nebs q _____ <input type="checkbox"/> Ipratropium 2.5 mL nebs q _____ <input type="checkbox"/> Bisacodyl 10mg suppositories _____ mg rectally q _____
		Antibiotics: <input type="checkbox"/> Ceftriaxone _____ gram IV q _____ hours x _____ doses, first dose in AM <input type="checkbox"/> Metronidazole _____ gram IV q _____ hours x _____ doses, first dose in AM Other antibiotic(s): <input type="checkbox"/> <input type="checkbox"/>
		Other medications: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Fingertick Blood Glucose(FSBS) <input type="checkbox"/> every 4 hours <input type="checkbox"/> AC and HS <input type="checkbox"/> _____
		<input type="checkbox"/> Sliding Scale Insulin (Regular) If FSBS < _____ mg/dL give _____ grams Dextrose _____ - _____ mg/dL give _____ units regular insulin _____ - _____ mg/dL give _____ units regular insulin _____ - _____ mg/dL give _____ units regular insulin _____ - _____ mg/dL give _____ units regular insulin _____ - _____ mg/dL give _____ units regular insulin _____ - _____ mg/dL give _____ units regular insulin If FSBS > _____ mg/dL call Physician

Physician Signature: _____ Pager: _____

GASTRIC BYPASS ORDERS