

**HOSPITAL  
PHYSICIAN ORDER FORM**

**PHYSICIANS:** All orders should be written generically and using the Metric System; include the physician's signature, PRINTED name, ID Number, beeper number and the date/time. A generically and therapeutically alternative drug as approved by the P & T Committee may be dispensed unless the order is specifically designated "Dispense as Written".

Form Approved by Medical Record Informatics Technology Committee: \_\_\_\_\_ (Revision 08/06)

**FAX  TITLE: EPIDURAL DEPO-MORPHINE (DEPODUR®) ADMINISTRATION ORDERS  
Adult patients only**

<b>DATE</b>	<b>This patient received an epidural dose of DepoDur® (Depo-Morphine) _____ mg at _____ hrs.</b>		
<b>TIME</b>	<b>(PLEASE CIRCLE OR CHECK APPROPRIATE ORDERS AND FILL IN BLANKS AS NEEDED)</b>		
<b>DIAGNOSIS:</b>		<b>ALLERGIES:</b>	
For questions or problems please call <b>REGIONAL ANESTHESIA AND ACUTE PAIN MANAGEMENT (RAAPM) TEAM (Pager _____)</b>			
<b>NURSING:</b> <ul style="list-style-type: none"> <li>- monitor and record RR, BP, P, SaO<sub>2</sub>, every 15 min for 1h following dose or upon arrival to PACU, q1h for 4 hours, q2h for 12h, then q4h for a total of 48 hours following dose administration time above</li> <li>- record pain location and intensity every four (4) hours</li> <li>- assess and record lower extremity motor and sensory function every four (4) hours</li> <li>- oxygen administration and self inflating bag/mask apparatus at head of bed</li> <li>- notify <b>RAAPM ( _____ ) STAT</b>, for respiratory rate &lt; 10/min, unable to arouse patient, or change in mental status</li> <li>- patient must have patent IV access for 48h postoperatively</li> <li>- Naloxone is located in the ACCUDOSE or CRASH CART if needed</li> </ul>			
1. Adjuvant analgesic orders (CHECK BOX AND CIRCLE DOSE BELOW):			
<input type="checkbox"/> Acetaminophen 650 mg OR 1000mg OR _____mg po q6h for pain. <input type="checkbox"/> _____			
2. Other medications (CHECK BOX AND CIRCLE DOSE BELOW):			
<input type="checkbox"/> Ondansetron _____ (4) mg IV q6h <input type="checkbox"/> Scopolamine _____ (1.5) mg / 72 hour patch apply for 72 hours <input type="checkbox"/> Metoclopramide _____ (10) mg IV q6h prn nausea <input type="checkbox"/> Diphenhydramine 12.5 mg OR 25 mg IV q6h or 25mg PO hs prn itching <input type="checkbox"/> Nalbuphine _____ (5) mg IV q6h prn itching			
3. Additional pain medications (CHECK BOX AND CIRCLE DOSE BELOW):			
<input type="checkbox"/> Morphine _____ (2) mg IV q1h prn moderate pain; Morphine _____ (4) mg IV q1h prn severe pain <input type="checkbox"/> Oxycodone _____ (10) mg PO q3h prn moderate pain, Oxycodone _____ (15) mg q3h prn severe pain <input type="checkbox"/> See IV PCA order sheet for IV pain medications to be administered in addition to dose of Depo-Morphine			
4. Page RAAPM Resident On-Call ( _____ ) for inadequate analgesia, itching or nausea not relieved by medications above, hypotension (systolic BP<90 mmHg), hypoxemia (SaO <sub>2</sub> < 93% on O <sub>2</sub> ), or urinary retention.			
<b>DATE:</b>	<b>TIME:</b>		
Physician Computer ID #	Physician SIGNATURE:	PRINT Physician NAME:	Beeper #:
Unit Secretary SIGNATURE:	TIME Sent to Pharmacy:	RN SIGNATURE:	