HARTFORD HOSPITAL
80 Seymour St. P.O. Box 5037
Hartford, CT 06102-5037

PRINTED BY HARTFORD HOSPITAL'S DIGITAL PRINT CENTER

Check box to initiate order

549437 R01/09

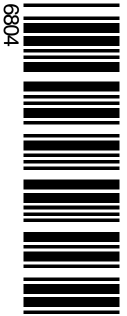
LAP NISSEN FUNDOPLICATION/ HELLER MYOTOMY

IMPORTANT
Position patient ID plate so it is to the LEFT of the arrow

ALLERGIC: ☐ NO ☐ YES

DATE/TIME MD SIGNATURE	PHYSICIAN'S ORDERS (excludes medication orders) (check box)	NOTED BY WHOM	DATE/TIME MD SIGNATURE	MEDICATION ORDERS (includes iv's bloods, blood components) (check box)	NOTED BY WHOM
	POST OPERATIVE ORDERS:			**Post-Op Orders:**	
				D 5 1/2 normal saline with 20 meq Potassium	
	Admit to Dr._________________ Please indicate			Chloride @ ____________ mL / hr	
	Surgical service: ☐ Blue ☐ Green			Discontinue Intravenous fluids on post oper-	
	Diagnosis: Gastroesophageal Reflux / Achalasia			ative day # 1 when taking p.o. and nausea free	
	Level of Care: Inpatient				
	Transfer to surgical unit when stable vital signs per				
	PACU routine, then surgical routine.			**Analgesia:**	
☐	DIET: NPO day of surgery, sips of clears evening of		☐	Morphine sulfate 2-10 mg subcutaneously every	
	surgery if no nausea/vomiting			three hours p.r.n. pain	
☐	POD #1 clears				
☐	POD #2 Lap Nissen Diet		☐	Hydromorphone (i.e. Dilaudid®) 2-4 mg p.o. every	
☐	Dietary teaching & consult post Lap Nissen diet			four hours p.r.n. pain	
☐	Activity: OOB to chair today				
☐	Ambulate ASAP			**Antiemetic:** Use alternate to antiemetic given	
☐	I/O			perioperatively or in PACU	
☐	Incentive spirometer: every hour when awake				
☐	Call House Officer if:		☐	Promethazine (i.e. Phenergan®) 12.5mg - 25mg	
	Temperature is > 101.5			IV/p.o. every 4 hours p.r.n. nausea and vomiting	
	Heart rate is > 120 or < 50		☐	Ondansetron (i.e. Zofran®) 4 mg IV every 6	
	Systolic Blood pressure is > 160 or < 90			hours p.r.n. nausea and vomiting	
				Please se page 2 for Vanco orders and	
				Rationale	

PHYSICIAN'S ORDER FORM

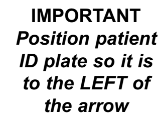


HARTFORD HOSPITAL
80 Seymour St. P.O. Box 5037
Hartford, CT 06102-5037

PRINTED BY HARTFORD HOSPITAL'S DIGITAL PRINT CENTER

Check box to initiate order

VANCOMYCIN ORDER AND RATIONALE



ALLERGIC: ☐ NO ☐ YES ____________________

DATE/TIME MD SIGNATURE	PHYSICIAN'S ORDERS (excludes medication orders)	NOTED BY WHOM	DATE/TIME MD SIGNATURE	MEDICATION ORDERS (includes iv's blood components)	NOTED BY WHOM
	If Vancomycin is the antibiotic of choice, please		☐	Vancomycin (ie Vancocin ®) 1 gm IV one dose	
	document the rationale by checking all that apply			infuse over 90 minutes. Start infusion in Pre-op	
				Line area.	
☐	Beta –Lactam, penicillin or cephalosporin allergy				
☐	Known prior colonization with MRSA				
☐	Acute inpatient hospitalization within the past year				
☐	Long Term care Resident within the past year				
☐	Increased MRSA rate, either facility-wide or procedure				
	specific				
☐	Presence of a chronic wound care or on dialysis				
☐	In-patient stay more than 24 hours prior to surgery				
☐	Other reason, please provide rationale:				
	____________________________________				
	____________________________________				
	____________________________________				

PHYSICIAN'S ORDER FORM