



Last Admit Date:

OB ADMISSION ORDERS

DIAGNOSIS	
ADMIT TO Dr. _____ (with Dr. _____ covering) <input type="checkbox"/> Hospitalist	
STATUS <input type="checkbox"/> Referred for Observation <input type="checkbox"/> Inpatient <input type="checkbox"/> OPS Expected LOS > two midnights <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
MEDICAL NECESSITY DATA (S&S, LAB/XRAY REPORTS etc)	
SERVICE <input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> ICU/IMCU <input type="checkbox"/> WH <input type="checkbox"/> OB/GYN <input type="checkbox"/> Pediatrics <input type="checkbox"/> Ortho	
CONDITION <input type="checkbox"/> Stable <input type="checkbox"/> Guarded <input type="checkbox"/> Poor <input type="checkbox"/> Critical <input type="checkbox"/> Continue DNR	
CONSULT <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Done <input type="checkbox"/> Page on Arrival <input type="checkbox"/> Page in AM	
CONTACT MD	<input type="checkbox"/> For any question/problems <input type="checkbox"/> In AM w/ room # <input type="checkbox"/> On arrival to floor <input type="checkbox"/> Further Orders
	1. NPO except ice chips
	2. <input type="checkbox"/> CBC with diff <input type="checkbox"/> RPR <input type="checkbox"/> Type & Screen if previous C-Section Urinalysis: <input type="checkbox"/> Routine <input type="checkbox"/> C&S
	3. Maintain IVF: <input type="checkbox"/> RL <input type="checkbox"/> D5RL <input type="checkbox"/> D5 1/2NS
	4. GBS prophylaxis if indicated
	5. Epidural anesthesia at 4cm's if desired – bolus RL if indicated
	6. <input type="checkbox"/> Foley, may use Xylocaine 1% gel as lubricant Reason—_____
	7. If no prenatal care: CBC, UA with micro and C&S, Rubella Titer, RPR, Type & Screen, HBSAG, Urine Drug Screen, HIV (must obtain patient's written consent)
	8. Preterm Labor less than 37 weeks, obtain Urine Drug Screen
	9. <input type="checkbox"/> mini prep <input type="checkbox"/> enema – fleets/ss
	10. Continuous Fetal Monitor
MEDICATION ORDERS (if Checked)	<input type="checkbox"/> Call Physician for meds <input type="checkbox"/> Zofran 4mg IVP every 4 hrs PRN N/V <input type="checkbox"/> Ambien 10mg PO every HS prn insomnia <input type="checkbox"/> Mylanta 30ml PO every 4 hrs prn indigestion/heartburn <input type="checkbox"/> Tylenol 650mg PO every 4 hrs prn headache, Maximum 4 gram dose in 24 hours <input type="checkbox"/> Carbocaine 1% or <input type="checkbox"/> Lidocaine 1% for episiotomy (Check one) <input type="checkbox"/> Cytotec 25 micrograms intra vaginally behind the cervix every 3 hrs per protocol <input type="checkbox"/> Pitocin Per Protocol
	Pain Management: (SELECT ONLY ONE) <input type="checkbox"/> Stadol 2mg SIVP every 2 hrs prn pain <input type="checkbox"/> Demerol 50mg <input type="checkbox"/> SIVP <input type="checkbox"/> IM <input type="checkbox"/> PO every 4 hrs prn pain

Physician Offices—
For the most updated form please visit
www.coffeeregional.org and
print from the "For Our Physicians" link.

Patient Name and DOB