



London Health Sciences Centre

Critical Care Trauma Centre
POST-OPERATIVE
PATIENT CARE ORDERS

KEY: R - REQUISITIONED P - PROCESSED (KARDEX)

THIS SECTION MUST BE COMPLETED AND SIGNED BEFORE MEDICATIONS ARE DISPENSED.					
<input type="checkbox"/> NO KNOWN ALLERGIES					
ALLERGY (drug, food, tape, dyes, latex, other)			REACTION		
1.					
2.					
3.					
NON-MEDICATION ORDERS		R	P	MEDICATION ORDERS	
<p>Reason for Exam / Clinical History and Contact # required for all Radiology / Nuclear Medicine orders.</p> <p><input type="checkbox"/> Parenteral Nutrition:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Enteral Nutrition:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Other:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>				<p><input type="checkbox"/> I.V.:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Antibiotics:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Medications:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	
<small>PRESCRIBER'S PRINTED NAME / SIGNATURE / CONTACT #:</small>		<small>DATE (YYYY/MM/DD):</small>		<small>TIME:</small>	
<small>PROCESSOR INITIALS:</small>	<small>DATE (YYYY/MM/DD):</small>	<small>TIME:</small>	<small>RN INITIALS:</small>	<small>DATE (YYYY/MM/DD):</small>	<small>TIME:</small>