

**Abdominal Pain Observation
Physician Orders**
ALLERGY STICKER

Date/Time:	Refer to Observation For Service of Dr. _____
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DO NOT USE ABBREVIATIONS: μ , mcg, u, iu, QD, QID, QOD, B.I.W., T.I.W., MgSO₄, MSO₄, MS, HISS, RISS, AD, AU, AS
Please check box to activate the order. Cross out (X) any blank spaces prior to signing orders.

Non-Medication Orders	Medication Orders
<input type="checkbox"/> Cardiac Monitoring: Indication _____	<input type="checkbox"/> IV fluids: _____
DX: Abdominal Pain	@ _____ ml/hr x _____ liters
<input type="checkbox"/> Vitals: Every 4 hours	<input type="checkbox"/> Analgesics: use the pain control order set
Diet (Check One): <input type="checkbox"/> Regular/house <input type="checkbox"/> Clear Liquids <input type="checkbox"/> NPO	<input type="checkbox"/> Acetaminophen 650 mg PO/PR every 6 hrs PRN
<input type="checkbox"/> Carbohydrate Controlled (1800 kcal/day, no conc. Sweets)	Pain Score 1 - 4 and/or Temp > 101F
<input type="checkbox"/> 2 gram Na <input type="checkbox"/> Pureed <input type="checkbox"/> Other: _____	<input type="checkbox"/> Famotidine (Pepcid) 20 mg <input type="checkbox"/> IV <input type="checkbox"/> PO (check route) twice daily
Activity (Check One): <input type="checkbox"/> Ambulate ad lib <input type="checkbox"/> OOB to BR	<input type="checkbox"/> For smokers: Nicotine (Nicoderm)
<input type="checkbox"/> Ambulate with assist <input type="checkbox"/> Other: _____	<input type="checkbox"/> 7 mg <input type="checkbox"/> 14mg <input type="checkbox"/> 21 mg (check one) patch topically Daily
<input type="checkbox"/> Intake and Output q shift	<input type="checkbox"/> Ondansetron (Zofran) 4 mg <input type="checkbox"/> IV <input type="checkbox"/> PO (check route)
<input type="checkbox"/> Insert saline lock	every 6 hours PRN nausea/vomiting
Labs at _____ (Check Box(es)): <input type="checkbox"/> CBC <input type="checkbox"/> Iytes	<input type="checkbox"/> Metoclopramide (Reglan) <input type="checkbox"/> 5mg <input type="checkbox"/> 10 mg (check one)
<input type="checkbox"/> other labs: _____	<input type="checkbox"/> IV <input type="checkbox"/> PO (check route) every 6 hours PRN nausea/vomiting
<input type="checkbox"/> O ₂ (circle): _____ per liter nasal; Other _____	Other Medications:
<input type="checkbox"/> Notify MD for: HR < 55 or > 100	
RR < 12 or > 25	
Temp < 96 F or > 100.4F	
SBP < 100, SBP > 170, DBP > 120	
SaO ₂ < 90%	
<input type="checkbox"/> CT Scan Abd: indication _____	
(Check Applicable) <input type="checkbox"/> PO Contrast <input type="checkbox"/> IV contrast	
<input type="checkbox"/> Ultrasound abdomen: indication _____	
<input type="checkbox"/> Ultrasound pelvis endovaginal: indication _____	
<input type="checkbox"/> Consult Dr. _____	
Reason for Consult: _____	

MD Signature: _____ Beeper #: _____ Date: _____ Time: _____