The Hospital of Central Connecticut

Headache Observation
Physician Orders

ALLERGY STICKER

Date/Time:	Refer to Observation For Service of Dr. _____

DO NOT USE ABBREVIATIONS: µ, mcg, u, iu, QD, QID, QOD, B.I.W., T.I.W., MgS04, MS04, 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
DX: Headache	☐ IV fluids: _____
☐ Vitals: Every 4 hours	@ _____ ml/hr x _____ liters
Diet (Check One): ☐ Regular/house ☐ Clear Liquids ☐ NPO	☐ Analgesics: use the pain control order set
☐ Carbohydrate Controlled (1800 kcal/day, no conc. Sweets)	☐ Acetaminophen 650 mg PO/PR every 6 hrs PRN
☐ 2 gram Na ☐ Pureed ☐ Other:	pain score 1-4 **and/or** Temp > 101F
Acitivity (Check One): ☐ Ambulate ad lib	☐ For smokers: Nicotine (Nicoderm)
☐ OOB to BR ☐ Ambulate with assist ☐ Other_____	☐ 7 mg ☐ 14mg ☐ 21 mg (check one) patch topically Daily
☐ Insert Saline lock	☐ Ondansetron (Zofran) 4 mg ☐ IV ☐ PO (check route)
Labs at _____ (check box(es)): ☐ CBC ☐ lytes	every 6 hours PRN nausea/vomiting
☐ other labs: _____	☐ Metoclopramide (Reglan) ☐ 5mg ☐ 10 mg (check one)
☐ O_2 (circle): ___ per liter nasal; Other _____	☐ IV ☐ PO (check route) every 6 hours PRN nausea/vomiting
☐ Notify MD for: HR < 55 or > 100	**Other Medications**:
RR < 12 or > 25	
Temp < 96 F or > 100.4F	
SBP < 100, SBP > 170, DBP > 120	
SaO_2 < 90%	
☐ Consult Dr. _____	
Reason for Consult: _____	

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