

GENERIC SUBSTITUTE UNLESS CHECKED

ORDERS ARE IN EFFECT UNLESS CROSSED OUT.
 Exceptions: Orders preceded by a box (☐) require a ✓ to initiate order.
 Orders with blanks indicate additional information is needed.

*Patient name: _____ *DOB: _____

*Date _____ *Diagnosis and ICD-10 code: _____

Allergies: _____

*Time _____ Code status: Full DNR Medications only Other (specify) _____

Draw: CBC CMP Hgb & Hct Other (specify) _____

Vascular access: Port PICC CVC Start SL

Access pain level prior to treatment:

Phenergan

- 25mg IM
- 50mg IM

Zofran

- 4mg IV
- 8mg IV
- 4mg ODT
- 8mg ODT

Toradol

- 60mg IM
- 30mg IV

Demerol

- 50mg IM
- 75mg IM
- 50mg IV
- 75mg IV

IV Hydration Bolus

- 1L NS
- 2L 1/2NS/D5W
- 1L D5W

Discharge patient when complete if stable and pain level is within tolerable range.

Additional orders: _____

*Physician signature

*Date

*Time

*Denotes field that must be completed by healthcare worker

FAX order form to 503-815-7515



Physician Order: Pain Management
 Adventist Health Tillamook
 1000 Third St., Tillamook OR 97141

{ Patient label }

Physician Order