

*Generic Substitute Unless Checked <input type="checkbox"/>	
ORDERS ARE IN EFFECT UNLESS CROSSED OUT	
EXCEPTIONS: ORDERS PRECEDED BY A BOX (<input type="checkbox"/>) REQUIRE A ✓ TO INITIATE ORDER	
ORDERS WITH BLANKS INDICATE ADDITIONAL INFORMATION IS NEEDED	
* Patient Name	* Date of Birth
* Date	* Diagnosis Allergies
* Time	Code Status <input type="checkbox"/> Full Code <input type="checkbox"/> DNR <input type="checkbox"/> Medications Only <input type="checkbox"/> Other (SPECIFY)
	Lab Draws <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> Hgb & Hct <input type="checkbox"/> Other (SPECIFY)
	Vascular Access <input type="checkbox"/> Port <input type="checkbox"/> PICC <input type="checkbox"/> CVC <input type="checkbox"/> Start SL
	Assess pain level prior to treatment Phenergan <input type="checkbox"/> 25 mg IM <input type="checkbox"/> 50 mg IM Zofran <input type="checkbox"/> 4 mg IV <input type="checkbox"/> 4 mg ODT <input type="checkbox"/> 8 mg IV <input type="checkbox"/> 8 mg ODT Toradol <input type="checkbox"/> 60 mg IM <input type="checkbox"/> 30 mg IV Demerol <input type="checkbox"/> 50 mg IM <input type="checkbox"/> 50 mg IV <input type="checkbox"/> 75 mg IM <input type="checkbox"/> 75 mg IV IV Hydration Bolus <input type="checkbox"/> 1L Normal Saline <input type="checkbox"/> 2L ½ Normal Saline/D5W <input type="checkbox"/> 1L D5W
	<input type="checkbox"/> Discharge patient when complete if stable and pain level is within tolerable range
	Additional Orders
	* Healthcare Provider's Signature _____

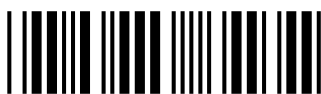
- * Denotes field that must be completed by Healthcare worker
- Note: Consent form must be signed by healthcare provider and patient prior to treatment with this medication

Fax to 503-815-7515

Tillamook County General Hospital – Adventist Health

Pain Management
Outpatient Therapy Services

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Physician Order Form

201005 Rev. 04/2012

[Patient Label]