

Your
Hospital's
Logo
Here

DILAUDID PCA PHYSICIAN'S ORDER SHEET

ALL ORDERS WILL BE FULFILLED UNLESS CROSSED OUT
**AFTER EACH ORDER IS PROPERLY CHECKED, FAX ORDER SHEET
 TO PHARMACY WHETHER OR NOT ORDERS INVOLVE MEDICATION.**

PATIENT IDENTIFICATION	Check (✓) Each Order As Transcribed	Check (✓) Pharmacy Orders	Allergy	
			DATE:	TIME: (Military Time)
			HYDROMORPHONE (Dilaudid) 1mg. / ml. INJECTION	
			PATIENT CONTROLLED ANALGESIA (PCA) ORDERS	
			1. Mode - Select one	
			PCA _____; Continuous _____; PCA + Continuous _____;	
			COMPLETE 2 thru 6	DOSING GUIDELINES
			2. PCA Dose =	ml. (mg.) 0.1 - 0.3 ml. (mg.)
			3. Delay between injections	minutes 10 minutes
			4. Basal (continuous) Rate	ml. (mg.) / hr 0 - 0.2 ml. (mg.) / hr
			5. One Hour Limit	ml. (mg.) 2 ml. (mg.)
			6. Initial Loading Dose	ml. (mg.) 0.4 - 1 ml. (mg.)
	FAXED BY/TIME:	TIME NOTED:	Doctor's Signature _____, MD Date _____ Nurse's Signature / Title _____ Date _____	

Military Time > >

PATIENT IDENTIFICATION	Check (✓) Each Order As Transcribed	Check (✓) Pharmacy Orders	Allergy		
			DATE:	TIME: (Military Time)	
			7. Narcan 0.4 mg. _____ 2 amps to be sent to floor		
			8. Hydromorphone (Dilaudid) 60 mg. / 60 ml. Normal Saline.		
			9. KVO IV must be maintained for duration of PCA Therapy.		
			10. Monitor respiratory rate, pulse, blood pressure, pain & LOC scores every 30 minutes x 2 hours, then every 4 hours until PCA is discontinued.		
			11. Call Dr. _____ or H.O. if patient complains of unrelieved pain, is difficult to arouse, is confused, or respiratory rate is < 12 per minute.		
			12. Instruct patient on proper use of PCA pump.		
			13. For drug compatibility questions, consult drug list or call Pharmacy.		
		FAXED BY/TIME:	TIME NOTED:	Doctor's Signature _____, MD Date _____ Nurse's Signature / Title _____ Date _____	

Military Time > >

USE BALL POINT PEN ONLY - PRESS FIRMLY

PART OF THE MEDICAL RECORD