Your Hospital's Logo Here

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
		PHYSICIAN'S ORDER
		DATE: **TIME:**
		POST OP ORDERS
		1. Admit to Recovery Room with Vital Signs per Routine.
		2. S / P Right / Left Cataract Surgery
		3. Condition: Stable
		4. Dressing: Eye Pad and Eye Shield on Left / Right Eye.
		5. Medications:
		Pilocarpine Ophthalmic solution (one gtt.) to Right / Left eye
		prior to Discharge
		6. Discharge Home per Anesthesia guidelines

FAXED BY/TIME: **TIME NOTED:**

Doctor's Signature _____,MD Date _____

Nurse's Signature / Title_____

MILITARY TIME > >

PATIENT IDENTIFICATION

Check (√) Each Order As Transcribed	Check (√) Pharmacy Orders	
		Allergy
		PHYSICIAN'S ORDER
		DATE: **TIME:**

FAXED BY/TIME: **TIME NOTED:**

Doctor's Signature _____,MD Date _____

Nurse's Signature / Title_____

MILITARY TIME > >

USE BALL POINT PEN ONLY - PRESS FIRMLY

PART OF THE MEDICAL RECORD