







Room #: _____ Patient Weight: _____ kg

Patient's Allergies & Type of Reaction (nursing to verify)	

PAIN SCALE

					
0	1	2	3	4	5
No Pain	Mild Pain	Moderate Pain	Severe Pain		

WARNING: DO NOT USE ABBREVIATIONS

- U, u
- IU
- Q.D, QD, q.d., qd
- Q.O.D, QOD, q.o.d., qod
- Trailing zero (X.0mg)
- Lack of leading zero (.Xmg)
- Any medication

PRE-OP OPHTHALMIC ORDERS - DR. SANG

Date _____ Time _____

MEDICATIONS

Check BP before administering eye gtts. If BP > 180/90 refer to Hypertension Algorithm and notify anesthesiologist.

Check Box for designated eye(s)

Proparacaine 0.5% Oph Sol OD OS OU
1 gtt

Moxifloxacin 0.5% Oph Sol OD OS OU
1 gtt

Flurbiprofen 0.03% Oph Sol OD OS OU
1 gtt Q 5 minutes x 2

Coll 3 & 38 ¼ strength Oph Sol OD OS OU
1 gtt Q 5 minutes x 3

Phenylephrine 5%/Tropicamide 0.8% Oph Sol
 OD OS OU 1 gtt Q 5 minutes x 3

Other _____

Ophthalmic Block OD OS

Retrobulbar Block by surgeon/fellow

Peribulbar Block by anesthesiologist

Topical

Intra Op Medications

Trypan Blue 0.06%

Mitomycin 0.2 mg/ml 0.4 mg/ml

Other _____

Latex allergy requires written order for Healon

ALL OTHER ORDERS

Diagnosis: _____

Intended Procedure: _____

Allergies & Reactions: _____

Past Medical History: _____

ORDERS:

Diet: NPO

Void on call to O.R.

Laboratory Tests: _____

Other _____

Responsible physician(s) for additional issues:

Resident _____ MD

Fellow _____ MD

Attending _____ MD

Date: _____ Time: _____

Ordering MD Signature: _____

Ordering MD Printed Name: _____

Ordering MD Beeper/Phone #: _____

PRE-OP OPHTHALMIC ORDERS - DR. SANG

DO NOT WRITE IN THIS SPACE