

EPIDURAL BLOCK PRE AND POST-OP PHYSICIAN ORDERS

Patient's Name: _____ Age: _____ Date: _____

Diagnosis: _____

Consent for: _____

Start IV - LR 50 cc/hour per TOSH IV policy Other: _____

NPO

Lab Work: _____

Medication: _____

Other: _____

Intra-op: X-ray C-arm Fluro scan

Physician Signature: _____ **Date:** _____ **Time:** _____

RN Signature: _____ **Date:** _____ **Time:** _____

PHYSICIAN POST-OPERATIVE ORDERS

Neuro/circ checks every _____ hour

Activity: as directed by physician

Follow up appointment: _____

Other: _____

Discharge when criteria met.

Patient had local anesthesia, no narcotic or sedative drug given. Patient may drive self home.

Physician Signature: _____ **Date:** _____ **Time:** _____

RN Signature: _____ **Date:** _____ **Time:** _____