CARDIAC SURGERY
POST- OPERATIVE ORDERS

ADMIT TO INPATIENT SERVICES: CCU

PROCEDURE DATE: ____________________ PROCEDURE: ____

ADMITTING SURGEON: ________________________________ INTENSIVIST: ____________________

ALLERGIES: ☐ NKA ALLERGIC TO: ____

Height (cm): ____________ Weight (kg): __________

CONSULTATIONS

☒ Cardiologist ___________________________________
☒ Cardiac Rehabilitation
☒ Consult Pharmacy re: Medication Profile Review
☒ Dr. Hammoud/Bakleh for management of all Diabetic Patients
☐ PCP ___________________________________
☐ ____

HEMODYNAMIC MONITORING:

1. VITAL SIGNS: Every 15 minutes and PRN until extubated and stable/ may progress to every 30minutes or hourly if STABLE.
2. DO NOT WEDGE SWAN
3. Continuous monitoring – ECG, Arterial Line, Cardiac Index/Cardiac Output, pulse oximetry, PAP, CVP and SVO2
4. Maintain these parameters. If not – call _______________________________

☐ CVP__________ ☐ PAP_____________ ☐ CO/CI_____________ ☐ SVO2___________

5. Temperature on admission and then hourly until temp 36.1C, then q4hrs and PRN. If temperature is below 36C, rewarm with BAIR Hugger/warm blankets
6. FOLEY TO GRAVITY DRAINAGE
   - ☒ DISCONTINUE FOLEY ON POD 2 unless otherwise ordered and documented.
   - ☒ If no urine output 8 hours post foley removal bladder scan if >200mL straight cath
   - ☒ Notify provider if initial straight cath and bladder scan have been completed and patient still unable to void 6 hours post straight cath.
7. INTAKE and OUTPUT q15min until patient extubated and then hourly.
   - ☒ Call ___________________if urine output less than 30 mL/hr for 2 consecutive hours.

____ ________________ ________________
Physician Signature **Date (required)** **Time (required)**

PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSE
Revised 3/18/2019

M – 1708 – 203

640B

PT.

MR.#/P.M.

DR.

CARDIAC SURGERY
POST- OPERATIVE ORDERS

8. CHEST TUBES – Connect to -20 cm water suction
   - ☒ Measure and Record Chest Tube Output q15 min x2 hours, then q30 min x4 hours, then q1 hour
   - ☒ Call Surgeon/NP if CT output >200 ml/hr
9. EPICARDIAL PACEMAKER MONITORING (record thresholds every shift, keep temporary pacer attached x24 hours for CABG patients and x48hrs for valve patients
   - ☒ Pace as necessary for HR less than 60
   - ☐ DDD include AV interval and rate
   - ☐ AAI include Rate, Atrial MA and Ventricular MA
   - ☐ VVI – Rate 60, Ventricular MA 20
10. INTRA-AORTIC BALLOON PUMP MONITORING
    - ☐ Set Pump at 1:1
    - ☐ Set Pump at 1:2
    - ☐ Set Pump at 1:3
    - ☐ Peripheral Pulse Check (while sheath or balloon in place) – q15minutes x2; q30minutes x2; then q1hour
11. NG/OG tube to low intermittent suction; remove NG/OG tube with extubation
12. DAILY WEIGHT at 0500 on same scale and record in kilograms
13. Soft Limb restraint- bilateral wrists while intubated x 24 hours to prevent injury

DIAGNOSTICS

- ☒ STAT ABG, CBC with diff, CMP, APTT, PT/INR, Magnesium, Ionized Calcium on admission to CCU
- ☒ STAT portable CXR on admission to CCU and routine at 0700 daily while in CCU
- ☒ STAT EKG on admission and at 0400 on POD 1 and PRN with changes.
- ☒ CBC 3 and 6 hours POST OP
- ☒ APTT, PT/INR, CBC, CMP, Mg, Ionized Calcium – POD 1
- ☒ Daily – CBC, CMP, starting POD 2
- ☒ Hemoglobin and Hematocrit - 2 hours post all PRBC transfusions
- ☒ ABG PRN Respiratory Distress and/or hemodynamic instability – call physician if abnormal
- ☐ Daily PT/INR

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PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSE

Revised 3/18/2019

M – 1708 – 203

640B

PT.

MR.#/P.M.

DR.

CARDIAC SURGERY
POST- OPERATIVE ORDERS

BLOOD SUGAR PROTOCOL: FOR ALL PATIENTS

☒ Glucometer Checks every 1 hour (even when drip is off) x 24 hours; call NP for further orders on non-diabetic patients after 24 hours

☒ Maintain Insulin infusion x 24 hours

☒ Initiate and titrate/manage insulin infusion utilizing the "Intravenous Insulin Order set and Adjustment Nomogram for Cardiac Surgery."

☒ Maintain blood sugar greater than 80 and less than 150 mg/dl.

☒ Resume insulin infusion if blood sugar is greater than or equal to **110 mg/dl**.

☒ Consult Endocrinology if blood glucose >180 mg/dl and not already on case.

☒ When patient is eating, initiate the following Prandial Insulin Scale based on current IV Insulin rate:

	Consumes >50% of Meal	Consumes 25-50% of Meal	Consumes < 25% of Meal
IV Insulin Infusion Rate units/hour	Insulin Lispro to be given within 10 minutes after breakfast, lunch, and dinner. Continue to follow IV Insulin Orders/Adjustment Guide with hourly glucose checks		
0-0.5 units/hour (or on HOLD)	3 units	2 units	0
1-1.5 units/hour	4 units	3 units	0
2-3 units/hour	6 units	4 units	0
4-5 units/hour	8 units	5 units	0
6-7 units/hour	10 units	6 units	0
8-10 units/hour	12 units	6 units	0
More than 10 units/hour	14 units	7 units	0

MEDICATIONS:

☒ ***Discontinue all pre-procedural medications. May utilize the TMO to specify all post-procedural medications***.

Maintain systolic blood pressure between _______________or MAP between ____________for first 12 hours.

VASODILATORS

☒ Clevidipine (Cleviprex) 2 mg/hr continuous infusion. Double dose every 90 seconds until approaching SBP goal, then increase by 1 mg/hr every 5 minutes. Max rate 21 mg/hr.

☐ Nitroglycerin 10 mcg/min continuous infusion. Increase by 5 mcg/min every 5 minutes to maintain goal SBP or MAP. (Max rate: 400 mcg/min)

VASOPRESSORS

☐ Norepinephrine 0.02 mcg/kg/min continuous infusion. Increase by 0.01 mcg/kg/min every 10 minutes to SBP goal. (Max dose 0.2 mcg/kg/min) Notify surgeon if dose increased by >50% starting dose.

☐ Dopamine 5 mcg/kg/min continuous infusion. Increase by 2.5 mcg/kg/min every 15 minutes until goal SBP or MAP is achieved. (Max dose: 20 mcg/kg/min)

☐ Epinephrine 0.01 mcg/kg/min continuous infusion. Increase by 0.01 mcg/kg/min every 10 minutes until goal MAP or SBP. (Max dose 0.1 mcg/kg/min) Notify Surgeon if dose increased by >50% starting dose

Physician Signature **Date (required)** **Time (required)**

640B

PT.

MR.#/P.M.

DR.

CARDIAC SURGERY
POST- OPERATIVE ORDERS

INOTROPES

☐ Milrinone 50 mcg/kg bolus over 10 minutes then 0.375 mcg/kg/min continuous infusion. Increase by 0.125 mcg/kg/min every 15 minutes until goal CI (Max rate: 0.75 mcg/kg/min)

☐ Dobutamine 2.5 mcg/kg/min continuous infusion. Increase by 2.5 mcg/kg/min every 10 minutes until goal CI. (Max dose: 20 mcg/kg/min)

RENAL PERFUSION

☐ Dopamine ___ mcg/kg/min continuous infusion. Maintain infusion until discontinued by provider. Normal dosing: 2-5 mcg/kg/min

RADIAL/LIMA/RIMA ARTERY SPASMS

☐ Diltiazem 125 mg/125 mL (Dose: 5mg/hour, flat rate)
☐ Nitroglycerin 50 mg/250 mL (Dose: 5mcg/min, flat rate)
☐ Nifedipine (PROCARDIA XL) 30 mg PO daily start on POD1
☐ Amlodipine 5 mg PO daily start on POD 1
☐ Cardizem CD 120 mg PO daily start on POD 1
☐ Discontinue IV Diltiazem/Nitroglycerin after oral dose started

ARRHYTHMIAS: NOTIFY SURGEON/NP if patient develops atrial or ventricular arrhythmias; Initiate ACLS protocol if patient unstable. Obtain and document EKG strip.

FOR ATRIAL FIBRILLATION/ ATRIAL FLUTTER with a ventricular rate greater than 120 BPM and hemodynamically stable initiate following protocol:

☒ AMIODARONE PROTOCOL: PRN A-Fib/Flutter with ventricular rate >120 BPM
- Bolus Amiodarone 150 mg IVPB over 10 minutes
- Start continuous IVPB infusion of Amiodarone 1 mg/min x 6 hrs then decrease to 0.5 mg/min X 18hours
- Discontinue Amiodarone infusion if heart rate is less than 70 BPM

☐ DILTIAZEM (CARDIZEM) PROTOCOL: PRN A-Fib/Flutter with ventricular rate >120 BPM
- Bolus Diltiazem (CARDIZEM) 0.25 mg/Kg over 2 minutes – (Max dose 25 mg)
- Start continuous IV infusion of Diltiazem (CARDIZEM) 125 mg/125 mL at 10 mg/hour
- Titrate continuous IV infusion of Diltiazem (CARDIZEM) by 1 mg/hr every 15 minutes to maintain Heart Rate greater than 70 BPM and Less than 110 BPM (Max Dose 20 mg/hr)
- Discontinue the Cardizem infusion if the Heart Rate is less than 70 BPM

IV FLUIDS/FLUID REPLACEMENT

☒ Volume Replacement – Give 500 mL Albumin IV over 1 hour x 2 doses-
PRN Volume Replacement
☒ 1 unit PRBC if Hgb less than 7 – call Surgeon before transfusion of any blood products
☒ Lactated Ringers at 50 mL / hour –Use Normal Saline at 50 mL / hour if Hemodialysis patient x24hours
☒ Normal Saline at KVO
☒ Saline flush every 8 hours for peripheral lines

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PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSE

Revised 3/18/2019

M – 1708 – 203

640B

PT.

MR.#/P.M.

DR.

CARDIAC SURGERY
POST- OPERATIVE ORDERS

SEDATION

☒ Propofol (DIPRIVAN) 10 mcg/kg/min continuous infusion. Increase by 10 mcg/kg/min every 5 minutes until RASS score of -2. Maintain RASS score of -2 until hemodynamically stable and ready to wean (per weaning protocol); when weaning, decrease rate by 5 mcg/kg/min every 5 minutes to RASS score to 0; discontinue Propofol prior to extubation. Contact physician if a rate of 90 mcg/kg/min is achieved.

ANALGESICS

MILD PAIN (Scale 1-3)

☒ Acetaminophen (OFIRMEV) 1000 mg IV given over 15 minutes – every 8 hours x 24 hours. (max dose of acetaminophen 3 gm/day); THEN Acetaminophen 650mg PO q6 hours PRN pain/fever (max dose 3GM/day)

MODERATE PAIN (Scale 4-6)- select only one

☐ Ultram 50 mg 1 tab PO every 4 hours once able to take oral pain medication
☐ Oxy IR 5 mg, 1 tab PO every 4 hours once able to take oral pain medication.
☐ Ketorolac (TORADOL) 15 mg IVP every 6 hours PRN for moderate pain x 4 doses. Hold for a Creatinine > 1.4

SEVERE PAIN (Scale 7-10) While Intubated- select only one

☐ Morphine 2 mg IVP every 2 hours PRN: may repeat 2 mg IVP in 15 minutes if severe pain unrelieved x 1 while intubated
☐ Dilaudid 0.5 mg IVP every 2 hours PRN for severe pain while intubated
☐ Fentanyl 50 mcg IVP every 2 hours as needed for severe pain while intubated

SEVERE PAIN (SCALE 7-10)- Post Extubation

☐ Oxy IR 5 mg 2 tabs every 4 hours for severe pain once able to take oral pain medications.

BREAKTHROUGH PAIN- Post-Extubation- select only one

☐ Morphine 2 mg IVP every 2 hours PRN: may repeat 2 mg IVP in 15 minutes if severe pain unrelieved for break through pain post extubation
☐ Dilaudid 0.5 mg IVP every 2 hours PRN for severe pain for break through pain post extubation
☐ Fentanyl 50 mcg IVP every 2 hours as needed for severe pain for break through pain post extubation.

PROPHYLACTIC ANTIBIOTICS

☒ Pharmacy to Dose

☐ Cefazolin (KEFZOL) – 2 gm (or 3 gm if patient ≥120kg)
DATE/TIME DOCUMENTED BY ANESTHESIA:
PRE OP DOSE: _____________ INTRA-OP DOSE (if given): ___________________
☐ Give 1st post op dose 4 hours after intra op dose (OR 8 hours after pre-op dose, if no intra op dose given) and then repeat every 8 hours x 4 additional doses to be discontinued within 48hours of surgery end time
☐ Give 1st post op dose 4 hours after intra op dose (OR 8 hours after pre-op dose, if no intra op dose given) and then repeat every 8 hours x 2 additional doses.

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Physician Signature **Date (required)** **Time (required)**

640B

PT.

MR.#/P.M.

DR.

CARDIAC SURGERY
POST- OPERATIVE ORDERS

IF ALLERGIC TO CEPHALOSPORIN or PENICILLIN:

☐ Vancomycin –1000 mg (or 1500 mg for patient ≥100 kg) - run over 90 minutes – First dose given in surgery by anesthesia when cardiopulmonary bypass completed:

DATE/TIME DOCUMENTED BY ANESTHESIA_______________

☐ Repeat every 12 hours x 3 additional doses to be discontinued within 48 hours of surgery end time.
☐ Repeat every 12 hours x 2 additional doses

IF NASAL CULTURE POSITIVE FOR MRSA OR URGENT CASE WITH NO MRSA SWAB RESULTED- GIVE KEFZOL IN ADDITION TO:

☐ Vancomycin –1000 mg (or 1500 mg for patient ≥100kg)- IVPB to run over 90 minutes – 12 hours after pre-op

Vancomycin IVPB dose given.
DATE/TIME DOCUMENTED BY ANESTHESIA ______________________________

BETA-BLOCKER (Hold if SBP less than 100 or HR less than 60) – START on POD 1

Metoprolol (LOPRESSOR) ☐ 12.5 mg PO/OG every 12 hours
☐ Other ____

Carvedilol (COREG) ☐ 3.125 mg PO/OG every 12 hours
☐ Other ____

Beta-blocker contraindicated due to: ______________________________

STATIN

☐ Atorvastatin (LIPITOR) 40 mg PO/OG daily
☐ Pravastatin ______ PO/OG daily
☐ Other ____

ANTIEMETICS/GASTROINTESTINAL

☒ Ondansetron (ZOFRAN) 4 mg IVP every 6 hours PRN for nausea.
☒ Metoclopramide (REGLAN) 10 mg IVP every 4 hours PRN nausea/vomiting, if Zofran ineffective.
☒ Famotidine 20 mg IVP BID until extubated; then Famotidine 20 mg PO BID

BOWEL ROUTINE – TO START POD 1

☒ Senna Concentrate/Docusate (SENOKOT S) 2 tablets PO every day
☒ Bisacodyl (DULCOLAX) suppository every day PRN and in AM of POD 3 if no BM
☒ Magnesium Hydroxide (MILK OF MAGNESIA) BID PRN and in AM of POD 4 if no BM

_______________________________________ _______________ ________________
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PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSE
Revised 3/18/2019

M – 1708 – 203

640B

PT.

MR.#/P.M.

DR.

CARDIAC SURGERY
POST- OPERATIVE ORDERS

VTE PROPHYLAXIS

☐ Heparin 5000 Units subcutaneously every 8 hours to start 8 hours after surgery, Hold if active bleeding or platelet count <100,000
☐ Arixtra (FONDAPARINUX) 2.5 mg subcutaneous daily to start on POD 1 (Contraindicated if CrCl <30), reserved for patients with Heparin allergy, active or suspected HIT.
☒ Intermittent Pneumatic Compression Device (IPC) worn at all times.
☐ Anti-embolic bilateral knee-high leg stockings

PLATELET INHIBITORS

☒ Aspirin –325 mg PO daily; start on POD 1
☐ Aspirin 300 mg Supp Rectally Once on arrival to CCU, while intubated
☐ Clopidogrel (PLAVIX) 75mg PO daily; start on POD 1

OTHER

☒ Cepacol Lozenges PO PRN for sore throat
☒ Hydralazine 10 mg IVP every 1 hour PRN for SBP >160 (use when trying to wean Cleveprex and/or Nitro drips or if reaching max doses of Cleveprex and/or Nitro drips).
☐ Alprazolam (XANAX) 0.25 mg BID PRN for anxiety
☐ Amiodarone 200 mg PO BID
☐ Other ____
☐ Other ____
☐ Other ____

ELECTROLYTE REPLACEMENT:

☒ ***HOLD ELECTROLYTE REPLACEMENT PROTOCOL FOR DIALYSIS PATIENTS***

☒ **IV Potassium Protocol (normal range 3.6-5.2 mEq/L)**

Potassium Level (mEq/L)	Potassium Chloride Dose Infusion Rate		Repeat K Level
	Central access with cardiac monitor	Peripheral IV access or central access without cardiac monitor	
Less than 3.2- Notify Physician	20 mEq/100 mL over 1 hour x 3 doses	10 mEq/100 mL over 1 hour x 6 doses	30 minutes after last dose infused
3.3-3.5	20 mEq/ 100 mL over 1 hour x 2 doses	10 mEq/ 100 mL over 1 hour x 4 doses	Next AM
3.6-3.9	20 mEq/ 100 mL over 1 hour x 1 dose	10 meq/100 mL over 1 hour x 2 doses	Next AM
Greater than 3.9	No treatment	No treatment	

_______________________________ ____________ ____________
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CARDIAC SURGERY
POST- OPERATIVE ORDERS

☒ **Magnesium Protocol (normal range 1.5-2.6 mg/dL) (*non-obstetrical use)***

Magnesium Level (mg/dL)	Magnesium Dose	Repeat Mg and SCr Level
Less than 0.8 - notify physician	2 gram Magnesium Sulfate IV x 4 doses	Next AM
0.8-1.1	2 gram Magnesium Sulfate IV x 3 doses	Next AM
1.2-1.4	2 gram Magnesium Sulfate IV x 2 doses OR 400 mg magnesium oxide by mouth every 4 hours x 2 doses	Next AM
1.5-1.9	2 gram Magnesium Sulfate IV x 1 OR 400 mg Magnesium oxide by mouth x 1 dose	Next AM

*IV replacement with 1 gram magnesium sulfate in 100 mL D5W for peripheral administration or 2 grams magnesium sulfate in 50 mL D5W for fluid restricted patients or central line administration, to be administered at a rate not to exceed 16 mEq (2 grams) per hour (or 1 gram per 30 minutes)

****If Serum Creatinine is greater than 2 mg/dL, use ½ the dose**

☒ **Calcium Gluconate Protocol**

Ionized Calcium	IV Calcium Gluconate Replacement and monitoring
Less than 0.9	28.2 mEq (6 gm) Calcium Gluconate IVPB over 6 hours; repeat ionized calcium 2 hours post dose and follow algorithm
0.9-0.99	18.8 mEq (4 gm) Calcium Gluconate IVPB over 4 hours; repeat ionized calcium 2 hours post dose and follow algorithm
1-1.1	9.4 mEq (2 gm) Calcium Gluconate IVPB over 2 hours; check ionized calcium next AM

* Infusion rate not to exceed 1 gm/hour Calcium Gluconate

****If GFR less than 30 mg/dL check phosphate. If phosphate greater than 7 mg/dL contact provider before replacing calcium**

RESPIRATORY: VENTILATION, WEANING & EXTUBATION PROTOCOL

- GOAL: Extubation within 24 hours, with ultimate goal within 6 hours if possible.
- Maintain the following parameters:
  - pH 7.32 - 7.48 (Notify physician if pH less than 7.25 or greater than 7.50)
  - $PaCO_2$ 32 - 50 mmHg
  - PaO_2 60 - 150 mmHg
  - SPO_2 greater than 92%
  - CI greater than 2
  - HCO_3 greater than 18 mMol/ L
- If patient awakes from anesthetic agitated and with a high respiratory rate greater than 24 bpm, change ventilator settings to PRVC at the same rate and FIO_2, give sedation.
- Wean FIO_2 as tolerated to keep SpO_2 greater than 92%
- EzPAP with unit dose Albuterol every 4 hours.
  - Respiratory Therapy to assess and evaluate the need for EzPAP or SVN.

Physician Signature | **Date (required)** | **Time (required)**

PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSE

Revised 3/18/2019

M – 1708 – 203

640B

PT.

MR.#/P.M.

DR.

CARDIAC SURGERY
POST- OPERATIVE ORDERS

- When patient fully awake, assess if patient meets the following criteria to wean
  - Hemodynamically stable
  - Temp greater than 36.1º F
  - Follow commands and communicates with meaningful gestures/nodding
  - No active bleeding
- If patient meets above criteria contact physician prior to weaning
- Start the ventilator weaning process by placing the ventilator to CPAP at 5 and PS (Pressure support) at 10, and current FIO_2. Repeat ABGs 30 minutes after each change.
- Target ventilation parameters to include:
  - Respiratory rate less than 25 breaths per minute
  - Tidal volume 3 - 4 mL /kg ideal body weight
  - RSBI (Rapid shallow breathing index) less than 105
- When CPAP and ABG parameters are within range call the intensivist for extubation orders. Monitor oxygen saturation with pulse oximetry and adjust to maintain 92% saturation.

If patient not extubated, return to prior ventilator settings and restart CPAP trial in am.

POST EXTUBATION

- All patients with BMI >30 need to be placed on Auto Bipap immediately after extubation for 4-6 hours and THEN nightly for at least 2 nights
- Extubate ALL patients with BMI >30 to Auto Bipap – Max IPAP 12, Min EPAP 4, PS 4
- Extubate ALL patients with BMI >35 to Auto Bipap – Max IPAP 14, Min EPAP 6, PS 4 for at least 2 nights.
- Incentive Spirometer 10 times every hour DOCUMENT how many MLs patients was able to achieve– deep breathing and coughing on all patients
- EzPAP with unit dose Albuterol every 4 hours.
  - Respiratory Therapy to assess and evaluate the need for EzPAP or SVN.
- ABG PRN Respiratory Distress – call surgeon and intensivist if abnormal
- Maintain SPO2 $\geq$ 92%

INCISION CARE:

- ☒ Remove chest dressing in am
- ☒ Clean incisions, chest tube sites, pacer wire sites every 12hours with Chlorhexidine, DO NOT rinse; if DermaBond used on incision – wash with soap and water, do not use Chlorhexidine
- ☒ Reapply chest dressing after each cleansing and document date, time and initials
- ☒ Remove leg/arm incision bandage and/or ace wrap on POD 1
- ☒ CHG bath daily in CCU
- ☒ Heart Hugger ALL male patients – Apply and Maintain
- ☒ Surgical Bra ALL female patients – Apply and Maintain

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PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSE

Revised 3/18/2019

M – 1708 – 203

640B

PT.

MR.#/P.M.

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CARDIAC SURGERY
POST- OPERATIVE ORDERS

DIET:

☒ NPO until 1 hours post extubation, then perform bedside swallow eval, ice chips as tolerates, then advance diet as tolerated with PO fluid restriction of 1,500 mL/24 hours. If patient is Diabetic, order the following diet – Women 1,500 Calorie, Men 1800 Calorie

ACTIVITY:

☒ Bedrest. Dangle if hemodynamically stable and extubated the night of surgery. Progress to up in chair by POD 1.
☒ POD 1 – Up to Chair TID -Ambulate in afternoon if no femoral arterial line present
☒ POD 2 – Up to Chair TID, Ambulate in hall TID
☒ POD 3 – Up to Chair TID, Ambulate in hall TID

Physician Signature ____________ Date (required) ____________ Time (required) ____________

640B

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MR.#/P.M.

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