

SERVICE	ATTENDING	RESIDENT
DIAGNOSIS/PROCEDURE	CONDITION	
SEE ORCA FOR ALLERGIES		

**Pre Operative Medications** (Does not apply to outpatient Pharmacy)

- Oxycodone                       10 mg PO x1 dose  
 Acetaminophen                 1000 mg PO x1 dose

**Intra Operative Medications** (Does not apply to outpatient Pharmacy)

- Ketorolac                         15 mg IV x1 dose     30 mg IV x1 dose

**PACU Medications** (Does not apply to outpatient Pharmacy)

- Oxycodone                       5-15 mg PO Q 3hr PRN  
 Hydrocodone/acetaminophen 5/500 mg     PO Q 4hrs PRN  
 Morphine SR                     15mg PO x1 dose     30 mg PO x1 dose  
 Other: \_\_\_\_\_

Patient High Risk for Post Op Nausea/Vomiting:

Pre OP

- Scopolamine patch 1.5 mg applied behind the ear x1 prior to surgery

Intra OP

- Dexamethasone 4 mg IV x1 dose  
 Ondansetron 4 mg IV x1 dose

**Postoperative Discharge Instructions**

- Discharge Patient when Surgery Center Criteria met.
- Review discharge instructions with patient.
  - Patient may shower. Keep dressing dry with plastic wrap.
  - Use sling postoperatively.
- Return to clinic  1 week  2 weeks  Roosevelt Bone and Joint Center  Eastside Subspecialty Clinic

**Discharge Medications**

**Number to be dispensed (write in full)** Eg. 20 (twenty)

- Docusate 100mg PO BID to prevent constipation ..... \_\_\_\_\_  
 Oxycodone 5 mg 1-3 tablets PO Q 3 hr PRN pain ..... \_\_\_\_\_  
 Morphine SR 15mg PO Q 12 hrs ..... \_\_\_\_\_  
 Meclizine 25 mg PO BID PRN nausea ..... \_\_\_\_\_  
 Hydrocodone/acetaminophen 5/500 mg PO Q 4hrs PRN ..... \_\_\_\_\_  
 Oxycodone/acetaminophen 5/325 mg 1-2 tablets PO Q 4 hr PRN pain ..... \_\_\_\_\_  
 Hydromorphone 2 mg PO q 4 hrs PRN break through pain ..... \_\_\_\_\_  
 Other: \_\_\_\_\_

Total number of prescriptions

Physician Instructions:

- Indicate the total number of prescriptions written in the box provided
- Draw a diagonal line through any unused lines or prewritten prescriptions not filled

**NO REFILLS ARE authorized for any prescription on this form**

PRINT Physician's Name Here	Physician No.	DEA No.	Date	Time
PHYSICIAN SIGNATURE (SUBSTITUTION PERMITTED)		PHYSICIAN SIGNATURE (DISPENSE AS WRITTEN)		

PT.NO

NAME

DOB

**UW Medicine**  
 Harborview Medical Center – UW Medical Center  
 University of Washington Physicians  
 Seattle, Washington

**PRE POST DISCHG RX ORDERS-SHOULDER SURG**

**\*U0000\***

\*U0000\*

UH0000 REV JUN 07

WHITE - MEDICAL RECORD  
 CANARY - PHARMACY  
 PINK - NURSING

PHYSICIAN ORDER - YELLOW