MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
DIRECTORATE OF NURSING SERVICES PATIENT FORMS	NAVHOSPPNCLAINST 5213.5A	20 Jun 2014

LOCAL FORM TITLE *(Optional)*
OB/GYN - POST OP CESAREAN SECTION ORDERS

Date: _____ **Time:** _____

1. **Admit:** Transfer to Recovery Room when stable
2. **Staff:**
3. **Vital signs:** Per Recovery Room routine/protocol, then every 4 hours on ward
4. **Allergies:**
5. **Diet:** ☐ NPO except sips and chips, advance diet as tolerated
   ☐ Clear liquids, advance diet as tolerated
   ☐ Regular, advance as tolerated
6. **Activity:** Strict bedrest until stable, then encourage ambulation with assist four times a day
7. **Intravenous:** LR with pitocin 20 units/L, infuse immediately after delivery, at 125 ml/hr x 2 hours, then LR at 125 ml/hr on ward
8. Flush Sod CHL 0.9% - Normal Saline Flush 3 ml IV Push Q shift and with each medication administration
9. **DVT Prophylaxis:** SCDs when in bed for 1st ☐ 12 hours ☐ 24 hours
10. **Incentive Spirometry:** 10-20 times every 1 hour while awake
11. Foley to gravity with I and O's Q shift when Foley present
12. **rhoGAM:** If mother Rh NEGATIVE, have baby's blood type on chart. Give rhoGAM per Blood Bank Protocol IF baby is Rh NEGATIVE. Document findings and actions on chart.
13. Fetal Blood Screen only
14. **LABS:** CBC in AM Post-Op Day #1
15. **Notify MO if:** TEMP > 100.4
    SBP > 140 or < 100
    DBP > 90 or < 50
    Heart Rate > 110 or < 60
    Urine output is < 30 mL over 2 hours
    Excessive bleeding
16. **Pericare:** Sitz bath three times a day as needed beginning 24 hours after delivery. Instruct pt to continue at home after discharge. Instruct patient on the use of peri bottle after voiding or stooling and to continue at home after discharge. Ice pack to perineum as needed during 1st 24 hours post op.

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	