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 - CESAREAN SECTION (POD #1) ORDERS

Date:_____ **Time:** _____

1. Discontinue Foley Catheter
2. Discontinue PCA
3. **Diet:** ☐ Clear Liquid. Pt may have coffee or tea. Advance to regular diet when tolerating clear liquids and passing gas.
   ☐ Regular diet with snacks for breastfeeding mother
4. Discontinue IV when tolerating clear liquids
5. **Medications:**
   - ☐ Flush sodium chloride 0.9% Normal Saline Flush 3ml IV Push Q shift and with each medication administration
   - ☐ Ibuprophen (Motrin) 800 mg tab PO q 8 hrs
   - ☐ Percocet (Oxycodone/APAP) (5-325MG) Give 1 tab PO q 4 hrs prn for pain (1-4) on pain scale
   - ☐ Percocet (Oxycodone/APAP) (5-325MG) Give 2 tabs PO q 4 hrs prn for pain (5-10) on pain scale
6. Patient may shower

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	