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 SURGICAL SERVICES PATIENT FORMS	NAVHOSPPNCLAINST 5213.7A	30 Jan 2014

LOCAL FORM TITLE *(Optional)*
ON-Q PAIN DELIVERY SYSTEM ORDERS

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(check as appropriate)

DATE OF PROCEDURE: _____

1. **Patient Allergies:**

2. **On-Q Pain Delivery System to be placed by:**

   ☐ Anesthesia (Select-A-Flow - On Demand) 400 ml volume

   ☐ General Surgery (Surgical Site Pump) 400 ml volume

   ☐ Obstetrics (Surgical Site Pump) 400 ml volume

   ☐ Orthopedics (Surgical Site Pump) 400 ml volume

3. **Patient's On-Q System to infuse:**

   ☐ Bupivacaine 0.5% MPF at _____ ml/hour, **Surgical Use Only**.

   ☐ Ropivacaine 0.2% at _____ ml/hour, Bolus dose = _____ (On Q pump on demand) **Anesthesia Use Only**

4. **Breakthrough Pain:** Contact Service who placed the On-Q Pump.

5. **Contact placing service for:**
   Pain or redness at insertion site
   Nausea or vomiting
   Blurred vision or dizziness
   Ringing in the ears
   Any concerns with pump or catheter

6. **Do not get catheter/site wet or place ice on top of the On-Q ball or catheter.**

7. **Provide patient with written instructions if On-Q pump in place at time of discharge.**

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	