

STANDARD ORDERS

Labour and Delivery

These orders are to be used as a guideline and do not replace sound clinical judgement and professional standards.
Patient allergy and contraindications must be considered when completing the orders.

- Automatically activated (if not in agreement cross out and initial) Activated by checking the box

MEDICATION ORDERS	GENERAL ORDERS
Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____ Patient's Weight: _____	
<p>DATE</p> <p>INTRAVENOUS</p> <p><input type="checkbox"/> Normal Saline or _____ rate at _____ mL/hour</p> <p><input type="checkbox"/> Intravenous saline lock</p> <p>MEDICATIONS</p> <p>Induction Options:</p> <p><input checked="" type="checkbox"/> Bishop's score _____</p> <p><input type="checkbox"/> Cervical Ripening Balloon</p> <p><input type="checkbox"/> Misoprostol 50 mcg Vaginal Suppository into posterior fornix, may repeat 6 hours after initial dose once, if necessary</p> <p><input type="checkbox"/> Prostaglandin E2 (Cervidil) 10 mg into posterior fornix x 1</p> <p><input type="checkbox"/> Misoprostol 20 mcg Oral Solution, initiate and titrate dosage until active labour is achieved using the Dissolve and Dose instructions and Dosing Protocol CLI.6010.SG.008.SD.04</p> <p><input type="checkbox"/> Oxytocin 30 units in 500 mL of Normal Saline intravenous, titrate to contractions as per Oxytocin Induction /Augmentation Guideline</p> <p>Analgesic Options:</p> <p><input checked="" type="checkbox"/> Nitrous Oxide (self-administered) via delivery system/face mask PRN for pain</p> <p><input checked="" type="checkbox"/> Intradermal sterile water injections 0.1 mL at each of 4 injection points PRN for pain as per practice guidelines</p> <p><input type="checkbox"/> Morphine _____ mg (usual dose 10 mg) subcutaneous/intravenous/ intramuscular, may repeat in 4 hours x 1 PRN for pain</p> <p><input type="checkbox"/> fentaNYL 50 mcg intravenous, then may repeat 50 mcg intravenous in 5 minutes x1, then may repeat 50 mcg intravenous q 30 minutes (usual maximum total doses do not exceed 200 mcg) PRN for pain then reassess</p> <p>Antiemetic Options:</p> <p><input checked="" type="checkbox"/> dimenHYDRINATE 25-50 mg intravenous/intramuscular/per rectum Q4H PRN for nausea or vomiting (maximum daily dose 400 mg)</p> <p><input type="checkbox"/> Metoclopramide 5 - 10 mg subcutaneous/intravenous/intramuscular Q6H PRN for opioid-induced nausea or vomiting</p> <p>Group B Streptococcus Prophylaxis Antibiotic Options (continue antibiotics per perinatal risk factors in the Group B Streptococcus in Mothers and Infants Guideline):</p> <p><input type="checkbox"/> Penicillin G 5 million units intravenous x 1 dose then 2.5 million units intravenous Q4H <u>OR</u>, if allergic to penicillin but <u>NOT</u> at risk for anaphylaxis:</p> <p><input type="checkbox"/> ceFAZolin 2 g intravenous x 1 dose, then 1 g intravenous Q8H <u>OR</u>, if allergic to penicillin <u>AND</u> at risk for anaphylaxis:</p> <p><input type="checkbox"/> Clindamycin 900 mg intravenous Q8H <u>OR</u>, if allergic to penicillin <u>AND</u> at risk for anaphylaxis <u>AND</u> if resistance to Clindamycin demonstrated by culture and sensitivity:</p> <p><input type="checkbox"/> Vancomycin 1 g intravenous Q12H</p>	<p>TIME</p> <p>NUTRITION</p> <p><input checked="" type="checkbox"/> Diet as tolerated</p> <p>TESTS</p> <p><input type="checkbox"/> CBC</p> <p><input checked="" type="checkbox"/> Cord Blood gases</p> <p>TREATMENTS</p> <p><input checked="" type="checkbox"/> Fetal monitoring as per guidelines</p> <p><input checked="" type="checkbox"/> Vital signs:</p> <p style="padding-left: 20px;"><input checked="" type="checkbox"/> BP, P, RR and T Q4h and PRN</p> <p style="padding-left: 20px;"><input checked="" type="checkbox"/> Temperature every 2 hours if greater than 37.6° or if membranes are ruptured</p> <p><input checked="" type="checkbox"/> Straight catheter prn</p> <p><input checked="" type="checkbox"/> Foley catheter prn</p> <p>CONSULTS</p> <p><input type="checkbox"/> Consult Anesthesia for epidural analgesia prn for pain</p>
PHYSICIAN / MIDWIFE SIGNATURE _____	PHYSICIAN / MIDWIFE PRINTED NAME _____
Order Transcribed Date: _____ Time: _____ Init: _____	COPY TO PHARMACY Date: _____ Time: _____ Init: _____