



STANDARD ORDERS Postpartum Vaginal 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.	
<input checked="" type="checkbox"/> Automatically activated (if not in agreement cross out and initial) <input type="checkbox"/> Activated by checking the box	
MEDICATION ORDERS	GENERAL ORDERS
Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes Describe _____ Patient's Weight _____	
DATE _____ TIME _____	
<p>INTRAVENOUS</p> <input type="checkbox"/> Normal Saline (NS) Rate at _____ mL/hour OR <input type="checkbox"/> _____ Rate at _____ mL/hour	<p>NUTRITION</p> <input checked="" type="checkbox"/> Diet as tolerated
<p><input checked="" type="checkbox"/> Discontinue intravenous when patient drinking well, voiding adequately, and afebrile</p> <p>MEDICATIONS Oxytocin Options:</p> <input checked="" type="checkbox"/> Oxytocin 5 units intravenous or 10 units intramuscular (preferred) Administer (choose one) <input type="checkbox"/> with delivery of anterior shoulder <input type="checkbox"/> after birth of baby <input type="checkbox"/> after delivery of placenta	<p>TESTS</p> <input type="checkbox"/> CBC <input checked="" type="checkbox"/> Perinatal Testing for Rh negative mothers 1 hour post delivery <input checked="" type="checkbox"/> Sexually transmitted and bloodborne infections (STBBI) – instruct DSM to send results to Primary Care Provider's office
<p><input checked="" type="checkbox"/> Oxytocin 40 units in 1000 mL of Normal Saline intravenous titrate to flow (usual rate 100-150 mL/hour) PRN for increased bleeding. Inform attending primary care provider.</p> <p>Analgesic Options:</p> <input type="checkbox"/> Acetaminophen 500 mg 1 to 2 tablets orally Q4H PRN for pain Maximum daily dose of acetaminophen from all orders not to exceed 4000 mg <input type="checkbox"/> Ibuprofen 400 mg orally TID PRN for pain Maximum daily dose 1200 mg OR <input type="checkbox"/> Naproxen 500 mg orally Q12H PRN for pain Maximum daily dose 1000 mg <input type="checkbox"/> Patient may self-administer <u>above</u> analgesic medications CLI.6010.PL.046	<p><input checked="" type="checkbox"/> Blood for STBBI panel <input checked="" type="checkbox"/> Urine for Chlamydia, Gonorrhea <input type="checkbox"/> Hepatitis C</p> <p>TREATMENTS</p> <input checked="" type="checkbox"/> Vital Signs and Assessment: Q15 min x 4, Q30 min x 2, then Q8H until 48 hrs then BID, and PRN until discharge <input checked="" type="checkbox"/> Straight catheterization PRN inability to void <input checked="" type="checkbox"/> Foley catheter PRN
<p>Other:</p> <input checked="" type="checkbox"/> PEG 17 grams orally daily (preferably at night) PRN to prevent constipation <input checked="" type="checkbox"/> Zinc Sulfate Hydrocortisone hemorrhoid ointment apply PRN for discomfort <input checked="" type="checkbox"/> Lanolin nipple cream apply PRN for discomfort <input checked="" type="checkbox"/> MMR 0.5 mL subcutaneously x 1 if rubella susceptible <input checked="" type="checkbox"/> If patient Rh Negative: Rh(D) Immune Globulin (human) 300 micrograms intravenous x 1 as per Rh Lab request OR if Rh Lab results not available at time of discharge (ensure consent is on chart)	<p>CONSULTS</p> <input type="checkbox"/> Social Worker <input type="checkbox"/> Lactation Consultant <input type="checkbox"/> Other _____ <p>DISCHARGE PLANNING</p> <input type="checkbox"/> Discharge when all outcomes are met Follow-up appointment in _____ days/weeks with: <input type="checkbox"/> Obstetrician <input type="checkbox"/> Family Physician <input type="checkbox"/> Midwife <input type="checkbox"/> Midwife attended birth, discharged at _____ hrs <input checked="" type="checkbox"/> Public Health Nurse referral
Priority PHN referral: <input type="checkbox"/> If discharged less than 24 hours (unless midwife is following) <input type="checkbox"/> Requires Newborn Universal Screening <input type="checkbox"/> Other: rationale _____	
PHYSICIAN/MIDWIFE SIGNATURE _____	PHYSICIAN/MIDWIFE PRINTED NAME _____
Order Transcribed Date: _____ Time: _____ Init: _____	COPY TO PHARMACY Date: _____ Time: _____ Init: _____