Spring Grove Hospital Center

Physician Medication, Non-Medication, and Admission Order Sheets

Department of Nursing Policy and Procedure

Purpose

To provide guidelines for taking off physician's orders and submitting to pharmacy.

Scope

The policy applies to all units.

Procedure

A. **Physician's Medication Order Sheet**

1. Stamp form with addressograph. If addressograph is not available, patient's name, hospital number, birth date and ward location must be printed legibly on area provided.

2. All medication orders must be written on Physician Medication Order Sheet (PMOS) and flagged.

3. Ten (10) medications can be ordered per medication order sheet. Five (5) medication orders may be written on each section of the PMOS, however, all orders within a section must be written by the same physician, including the indication for each medication.

4. When a single order is written on a section of the order sheet, a diagonal line must be drawn through the lower half of the section.

5. When a physician's order is discontinued, the discontinuation order will be written on the form by the physician.

6. List all reported allergies on the line provided at the top of the form. Allergies are to be written in red on top of sheet

7. After the order has been transcribed on the medication sheet, fax the order to the Pharmacy under a cover sheet. The original remains in the order book. Use the fax stamp to indicate that the order has been faxed to the Pharmacy, date and initialed.

8. The nurse who takes off the order must sign their name, classification, date and time on the line provided.

9. It is the responsibility of the medication nurse to review physician order sheets for new medication orders.

10. The night shift charge nurse is responsible for conducting a review of all patient records to assure all physician orders have been completed.

B. **Physician's Non-Medication Order Sheet**

1. Stamp form with addressograph.

2. When an order is discontinued or completed, the nurse will write the date, time and initials in the columns under "discontinued" heading. For example when laboratory tests are ordered, the nurse will take off the order and signs in the appropriate column. When the lab work is completed and the order is no longer in effect, the nurse will write the date, time and initials in the columns under "discontinued". Laboratory orders, X-rays, etc. will also be recorded on the back of the treatment sheet.

3. Non-medication orders include:

   a. admission
   b. vital signs
   c. diet and supplements*
   d. laboratory studies
   e. restricted activity
   f. various physical and psychiatric therapies available at the hospital
   g. precautions
   h. orders for LOA (Pass), Discharge, Transfer
   j. other non-medication orders and orders for physical restraint
   j. privilege level

4. The nurse who takes off the order must sign name, classification, date and time on the line provided.

5. Non-medication orders will be renewed every 60 days provided that there are no changes by the physician. Documentation should read "All current non-medication orders renewed for 60 days." (see exception)

6. Non-medication orders will be rewritten every 60 days.

*Exceptions: All dietary orders must be reviewed every 30 days.

B. **Admission Order Sheet**

1. Stamp form with addressograph.

2. Check patient information for accuracy.

3. Check observation level and precautions, and inform staff assigned to the unit of the special precaution or observation.

4. Implement the use of the form specific to the special observation.

5. Check privilege level.

6. Check Vital Sign Order. Implement vital signs flow sheet per order and check vital signs.

7. Check Diet
   a. Enter diet on TAR (If regular diet, no further action is needed).
   b. If the diet is not regular, complete a Dietary Referral Form with the appropriate diet, including food allergies and food preferences if applicable, and fax to Dietary.

8. Check Activity Restrictions

9. Check Diagnostic Testing
   a. Complete lab slips per doctor's order and put on the back of the TAR. Transcribe lab request orders on the back of TAR and stamp.
   b. Check consults and looks at required time it should be completed and is in accordance with policy.
   c. Check the Physician Order Sheet for the PPD Mantoux order of 0.5 tuberculin units to be given intradermal if applicable.

10. Check and ensure that History and Physical is done within 24 hours.

11. Check for admitting physician's signature and printed name.

12. The nurse taking the orders off must sign his or her signature, date and time on the form.

Attachments: Physician Order Sheet, Admission Order Sheet, and Non-Medication Order Sheet.

Approved by

4/27/18
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5-1-18
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Written: 8/92
Reviewed: 9/94, 1/97, 2/7/06, 7/08, 6/12, 11/15, 4/18
Revised: 8/6/98, 10/00, 10/01, 9/04, 9/07, 4/09, 8/16