DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

ALLERGIC REACTION

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of **ALLERGIC REACTION**		
		CONSULTS: [ ] _____		
		TREATMENTS: [ ] Pulse oximetry [ ] VS q4 hours [ ] IV Fluids_____at rate of_____ [ ] Respiratory Therapy_____ _____q_____hours		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: Specify dose, route, frequency [ ] Antihistamine: _____ [ ] Solumederol:_____ [ ] Topical Treatment: _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: _____		
		ACTIVITY: [ ] _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

ABDOMINAL PAIN

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of **ABDOMINAL PAIN**		
		CONSULTS: [ ]		
		TREATMENTS: [ ] D5-0.45 NS at rate of_____ [ ] VS q 4 hours [ ] CT [ ] U/S Radiology notified at _____hrs [ ] _____		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: specify dose, route, frequency [ ] Antiemetic:_____ [ ] Pain Management:_____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: [ ] NPO [ ] Clear Liquids As tolerated		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

ALTERED LEVEL of CONSCIOUSNESS
W/ POSITIVE SUBSTANCE SCREENING

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of ALTERED LEVEL OF CONSCIOUSNESS W/ POSITIVE SUBSTANCE SCREENING		
		CONSULTS: [ ] Trauma Service [ ] Social Work for substance abuse eval		
		TREATMENTS: [ ] Vital signs q 4 hrs as indicated [ ] IV D5 0.45 NS @ rate of _____/hr [ ] Oxygen saturation q 4 hours and PRN		
		ALLERGIES:		
		MEDICATIONS: [ ] Antiemetic: _____ [ ] Pain management:_____ [ ] _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET:		
		ACTIVITY: [ ] Bed Rest with bathroom privileges [ ] Activity as tolerates		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

ASTHMA

DATE	TIME	DOCTOR'S ORDERS		EDUC	NURSE
		[ ] Assign to CEU for Observation of **ASTHMA**			
		CONSULTS: [ ] Respiratory Therapy			
		TREATMENTS: [ ] O2 via cannula: _____l/min [ ] Pulse oximetry [ ] Peak flow q1 hour x 2, then q2 hours [ ] VS q4hr			
		ADVERSE DRUG AND FOOD REACTION:			
		MEDICATIONS: Specify dose, route, and frequency [ ] Albuterol Nebulizer:_____ [ ] Atrovent Nebulizer:_____ [ ] Solumedrol :_____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____			
		DIET:			
		ACTIVITY: [ ] Bed Rest with bathroom privileges [ ] Activity as tolerates			
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE**	**PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:			
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE**	**PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____			
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE**	**PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

BLUNT CHEST TRAUMA

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation & Treatment of BLUNT CHEST TRAUMA		
		CONSULTS: [ ] Trauma Surgery		
		TREATMENTS: [ ] D5 0.45NS at rate of_____hr [ ] VS Q4hrs [ ] Continuous Monitoring [ ] CK, CKMB, and Troponin Q4hrs X 3 [ ] EKG [ ] Radiology _____ [ ] Pulmonary Toilet by Respiratory Q4hrs PRN		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: specify dose, route, frequency [ ] Analgesics_____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: [ ] NPO [ ] Clear Liquids As tolerated		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

CELLULITIS

DATE	TIME	DOCTOR'S ORDERS		EDUC	NURSE
		[ ] Assign to CEU for Observation of CELLULITIS			
		CONSULTS: [ ] _____			
		TREATMENTS: [ ] IV Fluids _____hr [ ] VS Q4hrs [ ] Radiology_____			
		ADVERSE FOOD OR DRUG REACTIONS:			
		MEDICATIONS: specify dose, route, frequency [ ] Antibiotics _____ [ ] Analgesics _____ [ ] Antipyretic _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____			
		DIET: [ ] NPO [ ] Clear Liquids As tolerated			
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges			
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE**	**PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:			
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE**	**PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____			
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE**	**PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

Duke University Hospital

Doctor's Orders
E.D. Clinical Evaluation Unit
CHF EXACERBATION

Date	Time	Page 1 of 1 **Doctor's Orders**	EDUC	Nurse
		[ ] Assign to CEU for evaluation of Congestive Heart Failure		
		Consults: ? Cardiology Heart Failure [] Social Worker [] RN for educational needs: dietary modifications		
		Lab tests: ? CK, CK-MB (note time): 4 hr: _____, 8 hr: _____ ? Troponin T (note time): 4 hr: _____; 8 hr:_____ (timed from ED arrival/first draw; EDUC to send STAT) [] Dig level [] Repeat Chemistry [] ABG [] Magnesium [] OP4 [] Lipid profile		
		Diagnostic tests: ? EKG (note time): 4 hr: _____; 8 hr: _____; 12 hr: _____ and PRN change in patient status		
		Treatments: ? IV saline lock, flush per unit routine ? VS q 4 hours and PRN change in patient status ? Oxygen 2Lprn via nasal cannula. Pulse oximetry notify PA if <90% [] Strict I&O [] Foley cath placement prn diuresis		
		Medications: (specify dosages, route, frequency) DRUG AND FOOD ALLERGIES_____ ? IV Furosemide 40 mg IV ? Repeat IV Furosemide 80mg 3 hrs after initial dose ? Digoxin (if not therapeutic) Potassium Replacement _____ [] Repeat OP7 in 4 days Magnesium Replacement 2g IV over 1 hr if indicated ? Give patient their following regular daily medications: (order from Pharmacy) _____ _____ _____ _____ _____ _____		
		Diet: ? Step 1 AHA diet ? Diabetic Diet if indicated [] Fluid restriction 1500cc		
		Activity: ? Bedrest with bathroom privileges		
		PHYSICIAN SIGNATURE **ID#, DATE/TIME:**		
		ADDITIONAL ORDERS:		
		Functional Study: (choose one) reason for test: _____ ? Exercise Stress Test ? Exercise Stress Echo [] Definity contrast_____ ? *Other: (specify) _____ * (if ordering Nuclear Cardiology study, call 684-7744 to notify)		
		? **Other:** _____		
		PHYSICIAN SIGNATURE **ID#, DATE/TIME:**		
		PATIENT DISPOSITION: ? Admit _____ ? Discharge		
		PHYSICIAN SIGNATURE **ID#, DATE/TIME:**		

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

COPD EXACERBATION

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of **COPD EXACERBATION**		
		CONSULTS: [ ] Respiratory Therapy		
		TREATMENTS: [ ] O2 via cannula: _____l/min [ ] Pulse oximetry [ ] VS and peak flow q1hour x 2, then q4 hours [ ] _____		
		ALLERGIES:		
		MEDICATIONS: Specify dose, route, and frequency [ ] Albuterol Nebulizer :_____ [ ] Atrovent Nebulizer: _____ [ ] Solumederol :_____ [ ] Antibiotics: _____ [ ] Give patients their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET:		
		ACTIVITY: [ ] Bed Rest [ ] Bed Rest with bathroom privileges [ ] Activity as tolerates		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

VOMITING and DEHYDRATION

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of **VOMITING and DEHYDRATION**		
		CONSULTS: [ ] _____		
		TREATMENTS: [ ] Baseline Orthostatics and repeat q8 hours [ ] VS q4 hours [ ] D5-o.45NS at rate of _____ [ ] _____		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: Specify dose, route, and frequency [ ] Antiemetic: _____ [ ] Analgesic: _____ [ ] _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: NPO until vomiting ceases, then clear liquids as tolerated		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges [ ] Activity as Tolerated		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

FLUID and ELECTROLYTE IMBALANCE
In ESRD

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of FLUID/ELECTROLYTE IMBALANCE IN ESRD		
		CONSULTS: [ ] Nephrology (970-SPIN)_____		
		TREATMENTS: [ ] Saline Lock [ ] VS Q4hr [ ] Continuous Monitoring [ ] OP7, CA, MAG, PHOS at _____time [ ] EKG [ ] O2 _____l/min		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: specify dose, route, frequency [ ] Diuretics _____ [ ] Nitrates _____ [ ] BP meds _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: [ ] NPO [ ] Clear Liquids As tolerated		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

GI BLEED

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of GI Bleed		
		CONSULTS: [ ] GI Consult		
		TREATMENTS: [ ] D5.45NS at rate of _____ hr [ ] VS Q2hrs [ ] Labs: ABC Q4 hour x 2 [ ] Type & Screen [ ] [ ]		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: [ ] Zantac 50 mg IVPB Q80 [ ] Give patient their following regular daily medications: (Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: [ ] NPO		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

HEADACHE (WITH CNS SHUNT)

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation & Evaluation of HEADACHE WITH CNS SHUNT		
		CONSULTS: [ ] Neurology [ ] Neurosurgery		
		TREATMENTS: [ ] D5 0.45NS at rate of_____ [ ] VS Q4hrs [ ] Neuro Check Q2hr [ ] Labs _____ [ ] Radiology _____ [ ] Seizure Precautions		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: specify dose, route, frequency [ ] Analgesics _____ [ ] Antiemetic _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: [ ] NPO [ ] Clear Liquids As tolerated		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

HEMATURIA

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of HEMATURIA		
		CONSULTS: [ ] Urology [ ] _____		
		TREATMENTS: [ ] IV fluids _____ [ ] VS Q4hrs [ ] Continuous Bladder Irrigation [ ] Labs: H/H q4hrs x 2 [ ] OP7 q8hrs [ ] Others _____ [ ] Send a UA and culture [ ] Urine for cytology [ ] Assessment of home medication		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: specify dose, route, frequency [ ] _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: [ ] NPO [ ] Clear Liquids As tolerated		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

HYPERGLYCEMIA

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of HYPERGLYCEMIA		
		CONSULTS: [ ] Dietary [ ] _____		
		TREATMENTS: [ ] 0.9NS at rate of_____hr [ ] VS Q4hrs [ ] Accu Check Q1hr X 2 then Q2hrs [ ] OP7 [ ] EKG		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: specify dose, route, frequency [ ] Regular Insulin_____ [ ] Insulin/Sulfonurea_____ [ ] KCL IVPB _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: [ ] NPO [ ] Clear Liquids As tolerated		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

HYPOGLYCEMIA

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation & Evaluation of HYPOGLYCEMIA		
		CONSULTS: [ ] Dietary [ ] _____		
		TREATMENTS: [ ] IV fluids _____ [ ] VS Q4hrs [ ] Accu Check Q1hr X 2 then Q2hrs [ ] Labs:_____ [ ] Assessment of home medication		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: specify dose, route, frequency [ ] _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: [ ] NPO [ ] Clear Liquids ADA		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

IV ANTIBIOTICS FOR OPEN INJURIES

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of IV ANTIBIOTICS FOR OPEN INJURIES		
		CONSULTS: [ ] Trauma Service [ ] Orthopedics [ ] Plastics [ ] Other [ ] PRM/Social Work/Resource RN		
		TREATMENTS: [ ] Vital signs q 4 hrs as indicated [ ] IV D5 0.45 NS @ rate of _____/hr		
		ALLERGIES:		
		MEDICATIONS: [ ] Antibiotic: _____ [ ] Pain management:_____ [ ] _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET:		
		ACTIVITY: [ ] Bed Rest with bathroom privileges [ ] Activity as tolerates		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

MINOR PENETRATING WOUND

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation of MINOR PENTRATING WOUND		
		CONSULTS: [ ] Trauma Service		
		TREATMENTS: [ ] Vital signs q 4 hrs as indicated [ ] Oxygen saturation q 4 hrs as indicated [ ] IV D5 0.45 NS @ rate of _____/hr [ ] CXR and/or abdominal film in 4-6hrs		
		ALLERGIES:		
		MEDICATIONS: [ ] Pain management:_____ [ ] _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET:		
		ACTIVITY: [ ] Bed Rest with bathroom privileges [ ] Activity as tolerates		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

SYNCOPE

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation & Evaluation of SYNCOPE		
		CONSULTS: [ ]		
		TREATMENTS: [ ] 0.9NS at rate of_____hr [ ] VS Q4hrs [ ] Continuous Monitoring [ ] Neuro Check Q2hrs [ ] CK, CKMB, and Troponin Q4hrs X 2 [ ] EKG Q4hrs X 3 [ ] Labs _____ [ ] Contact CDU for Holter Monitor		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: specify dose, route, frequency [ ] _____ [ ] _____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: [ ] NPO [ ] Clear Liquids As tolerated		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	

DUKE UNIVERSITY HOSPITAL

DOCTOR'S ORDERS

ED CLINICAL EVALUATION UNIT

TOXICOLOGIC INGESTION

DATE	TIME	DOCTOR'S ORDERS	EDUC	NURSE
		[ ] Assign to CEU for Observation & Treatment of TOXICOLOGIC INGESTION/EXPOSURE		
		CONSULTS: [ ] Poison Control [ ] _____		
		TREATMENTS: [ ] D5 .45NS at rate of _____hr [ ] VS Q4hrs [ ] Accu Check Q1hr X 2 then Q2hrs [ ] Labs:_____ [ ] Continuous Monitoring [ ] EKG [ ] O2 _____l/min		
		ADVERSE FOOD OR DRUG REACTIONS:		
		MEDICATIONS: specify dose, route, frequency [ ] Charcoal with Sorbitol_____ [ ] Give patient their following regular daily medications:(Order from pharmacy) _____ _____ _____ _____ _____ _____		
		DIET: [ ] NPO [ ] Clear Liquids As tolerated		
		ACTIVITY: [ ] Bed Rest [ ] Bathroom Privileges		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		ADDITIONAL INITIAL ORDERS:		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	
		PATIENT DISPOSITION: [ ] Admit _____ [ ] Discharge _____		
DATE:	**TIME:**	**PHYSICIAN / PA SIGNATURE** / **PHYSICIAN / PA PRINTED NAME**	**PHYSICIAN ID#**	