

Check box to
initiate order

549006 R08/11

GYN/ONCOLOGY MD ORDERS

IMPORTANT
Position patient
ID plate so it is
to the **LEFT** of
the arrow

ALLERGIC: NO YES

DATE/TIME MD SIGNATURE	PHYSICIAN'S ORDERS (excludes medication orders)	NOTED BY WHOM	DATE/TIME MD SIGNATURE	MEDICATION ORDERS (includes iv's blood components)	NOTED BY WHOM
	Date of Service:				
	Follow-Up:				
	MD:				
	<u>SURGERY</u>				
	MD:				
	Procedure:				
	Diagnosis:				
	Clearance:				
	Bowel Prep:				
	<u>TESTS</u>				
	<input type="checkbox"/> CXR				
	<input type="checkbox"/> Mammogram				
	<input type="checkbox"/> CT Scan				
	<input type="checkbox"/> Colonoscopy				
	<input type="checkbox"/> Ultrasound				
	<input type="checkbox"/> Other				
	<input type="checkbox"/> MRI				
	<u>BLOOD WORK</u>				
	<input type="checkbox"/> Ca125				
	<input type="checkbox"/> LFTs				
	<input type="checkbox"/> hCG				
	<input type="checkbox"/> Coags				
	<input type="checkbox"/> CEA				
	<input type="checkbox"/> UA, C&S				
	<input type="checkbox"/> Cbc				
	<input type="checkbox"/> Type & Screen				
	<input type="checkbox"/> Chem7				
	<input type="checkbox"/> Other				
	<u>SPECIMENS OBTAINED</u>				
	<input type="checkbox"/> Pap				
	<input type="checkbox"/> Cervical Bx				
	<input type="checkbox"/> EMBx				
	<input type="checkbox"/> Vulvar Bx				
	<input type="checkbox"/> ECC				
	<input type="checkbox"/> Vaginal Bx				

PHYSICIAN'S ORDER FORM



6804