

**REMINDER: ALL MEDICATION ORDERS REQUIRE DOSE, ROUTE, FREQUENCY AND INDICATION
DO NOT USE ABBREVIATIONS**

DOCTORS ORDERS SINGLE SHOT SUBARACHNOID MORPHINE (DURAMORPH®) ORDERS	CHECK OFF/ INITIALS
1. This patient received subarachnoid Morphine (Duramorph®) at _____ hours.	
2. Keep ampule of Naloxone (Narcan®) 0.4mg/mL and 3mL syringe with needle at the patient's bedside.	
3. Check the patient's respiratory rate (without disturbing the patient, if possible) every hour x 24 hours after receiving subarachnoid Morphine.	
4. If patient's respiratory rate 9-10/minute and patient is easily aroused, give 0.2mg Naloxone (Narcan®) Intravenous and notify anesthesia department.	
5. If patient's respiratory rate is ≤ 8/minute and/or patient is difficult to arouse, give 0.4mg Naloxone (Narcan®) Intravenous and notify anesthesia department.	
6. FOR ITCHING:	
a. Diphenhydramine (Benadryl®) 25 mg Intravenous every 4 hours as needed	
b. If itching persists after 2 doses of Diphenhydramine (Benadryl®), give Nalbuphine (Nubain®) 2.5mg subcutaneous every 6 hours as needed	
c. If itching continues after 2 doses of Nalbuphine (Nubain®), give Naloxone (Narcan®) 0.08mg (1mL) Intravenous, (dilute 0.4mg Naloxone (Narcan®) with 4mL 0.9% Sodium Chloride in 5mL syringe). May repeat once in 5 minutes.	
7. FOR NAUSEA:	
a. Ondansetron (Zofran®) 4mg Intravenous slowly, if no response, may repeat once in 30 minutes.	
b. If nausea persists after 2 doses of Ondansetron (Zofran®), give Metoclopramide (Reglan®) 10mg Intravenous slowly over 2 minutes, if no response, may repeat once in 3 hours.	
c. If nausea continues after 2 doses of Metoclopramide (Reglan®,) give Prochlorperazine (Compazine®) 5mg Intravenous every 4 hours as needed.	
8. If patient unable to void, call anesthesia department.	
9. Keep Intravenous in place x 24 hours.	
10. No other parenteral narcotics or sedatives x 12 hours, unless cleared by anesthesiologist.	
11. Discontinue orders for Naloxone (Narcan®), Nalbuphine (Nubain®), Diphenhydramine (Benadryl®), Metoclopramide (Reglan®), Prochlorperazine (Compazine®), and Ondansetron (Zofran®) after 24 hours.	

Physician/Date/Time:	Nurse/Date/Time:	Secretary/Date/Time:
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Full page of orders requires only one physician, one nurse and one clerical signature



Original to Patient's Chart

Fax to Pharmacy