

PHYSICIAN'S ORDERS

Allergies:	Weight:	Height:	Admit TBSA _____ %
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Discontinue all previous dressing orders
 Notify MD if any change in appearance of surrounding skin or rash
 Notify MD if increased erythema, drainage, purulence or pain

Designate choice of topical antibiotic agent and wound dressing
Specify anatomic location and frequency

Wound Dressing/Therapy	Frequency	Location
<input type="checkbox"/> Hydrotherapy with wound care	<input type="checkbox"/> daily <input type="checkbox"/> every ____ days	Not applicable
<input type="checkbox"/> Burn Roll/Kerlix	<input type="checkbox"/> daily <input type="checkbox"/> every ____ days	_____
<input type="checkbox"/> Outer Compressive dressing	<input type="checkbox"/> daily <input type="checkbox"/> every ____ days	_____
<input type="checkbox"/> Coban	<input type="checkbox"/> daily <input type="checkbox"/> every ____ days	_____
<input type="checkbox"/> Post surgical dressings	Date of first dressing take down __ / __ / __	MD to fill diagram on the back of this page
<input type="checkbox"/> Integra	Must use with topical antibiotic agent (choose one below)	_____
<input type="checkbox"/> N-Terface		_____
<input type="checkbox"/> Beta-Glucan placed on	Leave open to air after 24 hrs	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____

Topical Antibiotic Agents	Frequency	Location
<input type="checkbox"/> Silver Sulfadiazine 1% Cream (Silvadene®)	<input type="checkbox"/> every 24 hours <input type="checkbox"/> every 12 hours	_____
<input type="checkbox"/> Mafenide Acetate 8.5% Cream (Sulfamylon®)	<input type="checkbox"/> every 24 hours	_____
<input type="checkbox"/> Mupirocin 2% Ointment (Bactroban®)	<input type="checkbox"/> every 12 hours <input type="checkbox"/> every ____ hours	_____
<input type="checkbox"/> Mupirocin 2% Ointment + Xeroform	Every ____ day(s)	_____
<input type="checkbox"/> Mepilex Ag	Every ____ days	_____
<input type="checkbox"/> Mafenide Acetate 5% Topical Solution	<input type="checkbox"/> 60 mL every 6 hours <input type="checkbox"/> ____ mL every 6 hours	_____
<input type="checkbox"/> Mafenide Acetate 5% Topical Solution 1000 mL with Nystatin 10 million units	<input type="checkbox"/> 60 mL every 6 hours <input type="checkbox"/> ____ mL every 6 hours	_____
<input type="checkbox"/> Aquacel Ag	Every ____ days	_____
<input type="checkbox"/> Exsalt (keep moist with sterile water every 6 hours)	Change every ____ days	_____
<input type="checkbox"/> Exsalt (do not moisten)		_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____

Date	Time Written	Physician's Signature	IMPRINT ID CARD (NAME MRUN CLINIC/WARD)		
Physician's ID Number		Service			
RN's Signature		Date			Time
Scanned By					

POST-OP SURGICAL DRESSINGS

Date _____

Designate on diagram:

- Location and type of surgical dressings placed.
- Location of ports of rubber catheters for irrigation.
- Location of donor sites and types of dressings placed.

