



PROVIDER ORDERS

SUR GENERAL SURGERY PRE-OP (3040100182)

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Location

<input type="checkbox"/> Boise Surgery Fax: 381-3060	<input type="checkbox"/> Boise COU Fax: 381-3567	<input type="checkbox"/> Surgery Center Boise Fax: 381-3209	<input type="checkbox"/> Surgery Center Meridian Fax: 706-8102
<input type="checkbox"/> Boise Endo Fax: 381-2135	<input type="checkbox"/> Meridian Endo Fax: 706-5015	<input type="checkbox"/> Meridian Surgery Fax: 706-2178	<input type="checkbox"/> Wood River OR/Endo Fax: 727-8634
<input type="checkbox"/> OSC – River Street Fax: 336-1954	<input type="checkbox"/> OSC – Robbins Fax: 489-4348	<input type="checkbox"/> Magic Valley Fax: 814-2921	<input type="checkbox"/> Elmore Fax: 580-9808
<input type="checkbox"/> Jerome Fax: 324-7301	<input type="checkbox"/> McCall Fax: 634-3818	<input type="checkbox"/> Nampa Fax: 205-7486	

Patient Name (First, middle initial and last): _____
 Date of Birth: _____ Phone Number: _____ Case Number: _____ Date of Surgery: _____
 Provider Name: _____ Allergies: _____
 Weight: _____ kg Height: _____ cm Diagnosis: _____ Interpretation Services; Language: _____

Pre Admission Testing N/A

<input type="checkbox"/> CBC	<input type="checkbox"/> Hepatic Function Panel
<input type="checkbox"/> APTT	<input type="checkbox"/> Urinalysis w/C&S if indicated
<input type="checkbox"/> Prottime-INR	<input type="checkbox"/> MRSA and SA Screen by PCR
<input type="checkbox"/> Basic Metabolic Panel	<input type="checkbox"/> ECG 12 lead (obtain if no ECG results within 30 days)
<input type="checkbox"/> Comprehensive Metabolic Panel	<input type="checkbox"/> ECG 12 lead (obtain if no ECG results within 6 months)
<input type="checkbox"/> Glycohemoglobin A1C	<input type="checkbox"/> XR chest 2 view
<input type="checkbox"/> Other: _____	

OR Code Status (Pre-Op)

<input checked="" type="checkbox"/> Default Full Code (Not Discussed)	<input type="checkbox"/> Modified code
<input type="checkbox"/> Full code	<input type="checkbox"/> DNR/DNI

Code Status – After choosing the appropriate code status please indicate whether this code status will be respected or suspended in the OR

<input checked="" type="checkbox"/> Respect Current Code Status	<input type="checkbox"/> Suspend Code Status (Full Code in OR)
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General (Pre-Op)

<input type="checkbox"/> Admit to Inpatient	<input type="checkbox"/> Hospital Outpatient Surgery (discharge home from PACU)	<input type="checkbox"/> Hospital Outpatient Surgery (with bed)
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Diet (Pre-Op)

<input checked="" type="checkbox"/> Adult NPO Diet	<input type="checkbox"/> Other: _____
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Nursing (Pre-Op)

<input checked="" type="checkbox"/> Sequential compression device	<input checked="" type="checkbox"/> Calf	<input type="checkbox"/> Thigh	<input type="checkbox"/> Insert Indwelling Urinary Catheter	Reason: Pre-Surgery/Pre-Procedure
<input checked="" type="checkbox"/> Verify informed Consent (exact wording for surgery consent): _____				

Labs (Pre-Op / Day of Surgery) N/A

<input type="checkbox"/> CBC	<input type="checkbox"/> Prottime-INR
<input type="checkbox"/> APTT	<input type="checkbox"/> Basic Metabolic Panel
<input type="checkbox"/> Comprehensive Metabolic Panel	<input type="checkbox"/> Glycohemoglobin A1C
<input type="checkbox"/> Urinalysis w/C&S if Indicated	<input type="checkbox"/> MRSA and SA Screen by PCR nasal only
<input checked="" type="checkbox"/> POCT blood glucose if diabetic	<input checked="" type="checkbox"/> POCT urine pregnancy policy
<input type="checkbox"/> Other: _____	<input type="checkbox"/> HCG urine pregnancy

Blood Bank Tests and Products (Pre-Op)

If preparing blood for a planned surgery, a Type and Screen needs to be resulted within 72 hours of product administration.

<input type="checkbox"/> Type and Screen	
<input type="checkbox"/> Prepare RBC	<input type="checkbox"/> 1 unit <input type="checkbox"/> 2 units
Indications: Surgical Blood Product	
Donor source options: <input type="checkbox"/> Blood Bank <input type="checkbox"/> Autologous	Request for special products: <input type="checkbox"/> CMV Negative <input type="checkbox"/> Irradiated

Imaging (Pre-Op / Day of Surgery) N/A

<input type="checkbox"/> XR chest 2 view	<input type="checkbox"/> Other: _____
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Patient Name (First, middle initial and last): _____

Procedures and Other Tests (Pre-Op) N/A

- ECG 12 lead (New order to be completed day of surgery) Other: _____
- ECG 12 lead (obtain if no ECG results within 30 days)
- ECG 12 lead (obtain if no ECG results within 6 months)

Referral (Pre-Admission Testing) N/A

- Outpatient referral to Perioperative Medicine (TV ONLY) Reason for referral: _____

IV (Pre-Op)

- Initiate IV protocol - Adult Sodium chloride 0.9% infusion at 25 mL/hr
- Lactated ringers infusion at 25 mL/hr Other: _____

Antibiotics (Pre-Op) N/A

- ceFAZolin (ANCEF) IVPB 2 g x 1 dose; one hour prior to incision time
- clindamycin (CLEOCIN) IVPB 900 mg x 1 dose; one hour prior to incision time
- piperacillin-tazobactam (ZOSYN) IVPB 3.375 g x 1 dose; one hour prior to incision time
- ampicillin-sulbactam (UNASYN) IVPB 3 g x 1 dose; one hour prior to incision time
- levofloxacin (LEVAQUIN) IV 500 mg x 1 dose; one hour prior to incision time
- metronidazole (FLAGYL) IVPB 500 mg x 1 dose; one hour prior to incision time
- cefoTEtan (CEFOTAN) IVPB 2 g x 1 dose; one hour prior to incision time
- vancomycin (VANCOCIN) IVPB 1 g x 1 dose; two hours prior to incision time
- Other: _____

Other Medications (Pre-Op) N/A

- Heparin subcutaneous injection 5,000 units x 1 dose Heparin subcutaneous injection 7,500 units x 1 dose
- Enoxaparin (Lovenox) subcutaneous injection 30 mg x 1 dose Enoxaparin (Lovenox) subcutaneous injection 40 mg x 1 dose

Anesthesia N/A

- Bier Block Epidural
- General Local with Conscious Sedation (No Anesthesia resource involved)
- Local with NO Sedation (No Anesthesia Resource involved) MAC
- N/A (No Anesthesia Resource involved) Regional Block
- SAB TBD by Anesthesia
- TIVA

Type of Optional Post-Op Analgesia N/A

- Adductor canal Bier block
- Caudal Epidural
- Fascia iliaca Femoral
- Interscalene Non specified Brachial plexus block
- Popliteal Saphenous
- Sciatic Spinal with Morphine
- Transverse Abdominis Plane Anesthesia providers choice
- Other – Comment Required

Additional Orders (any medication orders must include medication, dose, route and phase of care) N/A

PROVIDER SIGNATURE:

DATE:

TIME:

PATIENT LABEL