



PROVIDER ORDERS

PED GENERAL SURGERY PRE-OP (3040100527)

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"/> Comprehensive Metabolic Panel	<input type="checkbox"/> MRSA and SA Screen by PCR
<input type="checkbox"/> APTT	<input type="checkbox"/> Glycohemoglobin A1C	<input type="checkbox"/> ECG 12 lead
<input type="checkbox"/> Prottime-INR	<input type="checkbox"/> Hepatic Function Panel	<input type="checkbox"/> XR chest 2 view
<input type="checkbox"/> Basic Metabolic Panel	<input type="checkbox"/> Urinalysis w/C&S if Indicated	<input type="checkbox"/> Other: _____

General (Pre-Op)

Admit to Inpatient Hospital Outpatient Surgery (discharge home from PACU) Hospital Outpatient Surgery (with bed)

Diet (Pre-Op)

Pediatric NPO Diet Other: _____

OR Code Status (Pre-Op)

Default Full Code (Not Discussed) Modified code
 Full code DNR/DNI

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

Respect Current Code Status Suspend Code Status (Full Code in OR)

Nursing (Pre-Op)

Sequential compression device Calf Insert Indwelling Urinary Catheter; Reason: Pre-Surgery/Pre-Procedure
 Verify informed Consent (exact wording for surgery consent): _____

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

<input type="checkbox"/> CBC	<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"/> Urine Culture
<input type="checkbox"/> Urine HCG Screen	<input type="checkbox"/> MRSA and SA Screen by PCR nasal only
<input type="checkbox"/> POCT blood glucose if diabetic	<input checked="" type="checkbox"/> POCT urine pregnancy per policy
<input type="checkbox"/> Type and Screen	<input type="checkbox"/> Other: _____

Blood Bank Tests and Products (Pre-Op) N/A

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

Type and Screen Prepare RBC (greater than or equal to 40 kg 1 unit 2 units Indications: Surgical Blood Product

mL Blood Administration –Red Blood Cells – Ped less than 40 kg - Indicate volume desired in primary aliquot. All blood products are leukodepleted.
 Suggested Volume 15 mL/kg Volume _____ mL (indicate volume desired in PRIMARY aliquot up to 55mL)
 If volume greater than 55 mL is needed please indicate additional aliquots below.
 Donor source options: Blood Bank Autologous Request for special products: CMV Negative Irradiated

mL Blood Administration –Red Blood Cells – Ped less than 40 kg - Indicate volume desired in primary aliquot. All blood products are leukodepleted.
 Suggested Volume 15 mL/kg Volume _____ mL (indicate volume desired in SECONDARY aliquot up to 55mL)
 If volume greater than 55 mL is needed please indicate additional aliquots below.
 Donor source options: Blood Bank Autologous Request for special products: CMV Negative Irradiated

NOTE: If more than two aliquots are needed, indicate number of additional aliquots and volume in each _____

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

XR chest 2 view Other: _____

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

ECG 12 lead within 6 months Echo Pediatric Complete

	PROVIDER INITIALS:	PATIENT LABEL
DOWNTIME FOR EPIC FORM NUMBER 3040100527 10/01/16 rev. 04/25/17	Page 1 of 2	



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Patient Name (First, middle initial and last): _____

IV

- Initiate IV protocol – Pediatric lactated ringers infusion _____ ml/hr Other: _____
- dextrose 5 % and sodium chloride 0.45 % infusion _____ ml/hr dextrose 5 % and sodium chloride 0.9 % infusion _____ ml/hr

Antibiotics (Pre-Op) N/A

General (Pre-Op)

- ampicillin (OMNIPEN) IV (NEO/PED) 50 mg/kg x 1 dose
- ampicillin-sulbactam (UNASYN) dose band syringe (PED) 75 mg/kg of ampicillin x 1 dose
- ceFAZolin (ANCEF) 100 mg/mL IV syringe (NEO/PED) 25 mg/kg x 1 dose
- ceFAZolin (ANCEF) dose band syringe (PED), 25 mg/kg x 1, IV
- ceftOTETAN (CEFOTAN) 40 mg/mL IV syringe (NEO/PED) 40 mg/kg x 1 dose
- clindamycin (CLEOCIN) IV syringe (NEO/PED) 10 mg/kg x 1 dose
- gentamicin 2.5 mg/kg IV syringe (NEO/PED) x 1 dose
- metronidazole (FLAGYL) IV syringe (NEO/PED) loading dose 15 mg/kg x 1 dose
- metronidazole (FLAGYL) IV syringe (NEO/PED) maintenance dose 7.5 mg/kg x 1 dose
- piperacillin-tazobactam (ZOSYN) 100 mg/mL IV syringe (NEO/PED) 80 mg/kg of piperacillin x 1 dose for Patients 2 - 9 months of age
- piperacillin-tazobactam (ZOSYN) 100 mg/mL IV syringe (NEO/PED) 100 mg/kg of piperacillin x 1 dose for Infants greater than 9 months and Children and Adolescents less than or equal to 40 kg
- piperacillin-tazobactam (ZOSYN) 100 mg/mL IV syringe (NEO/PED) 3.375 g IV of piperacillin x 1 dose for Adolescents greater than 40 kg
- Pharmacy to dose aminoglycoside: _____
- Other: _____

Neurosurgery (Pre-Op) N/A

- ceFAZolin (ANCEF) 100 mg/mL IV syringe (NEO/PED) 30 mg/kg x 1 dose
- ceFAZolin (ANCEF) dose band, 30 mg/kg x 1, IV
- cefUROXime (ZINACEF) 90 mg/mL IV syringe (NEO/PED) 50 mg/kg x 1 dose, administer over 15 minutes
- vancomycin (VANCOCIN) 10 mg/kg IV syringe (NEO/PED) x 1 dose
- IP consult to Pharmacy Reason for consult: Dose vancomycin Comments: Pharmacy to adjust for renal function
- Other: _____

ENT (Pre-Op) N/A

- amoxicillin (AMOXIL) 400 mg/5 mL suspension 50 mg/kg x 1 dose
- ampicillin-sulbactam (UNASYN) 45 mg/mL IV syringe (NEO/PED) 50 mg/kg of ampicillin x 1 dose
- ampicillin-sulbactam (UNASYN) dose band syringe (PED) 75 mg/kg x 1 IV
- azithromycin (ZITHROMAX) 200 mg/5 mL oral suspension 10 mg/kg x 1 dose
- ciprofloxacin-dexamethasone (CIPRODEX) otic suspension 3 drops x 1 Dose, re-label for home use Both Ears Left Ear Right Ear
- mupirocin (BACTROBAN) 2 % ointment Once, Topical, For 1 Dose. Apply ointment to each nostril 3 times daily. Re-label for home use
- Other: _____

Anesthesia N/A

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

Type of Optional Post-Op Analgesia N/A

- Adductor canal Popliteal Epidural
- Caudal Sciatic Femoral
- Fascia iliaca Transverse Abdominis Plane Non specified Brachial plexus block
- Interscalene Bier block Saphenous
- Spinal with Morphine 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