

Surgical Services: Elective Surgery Order Sheet

Patient Name _____ DOB _____ Surgeon _____

Procedure _____

Diagnosis _____

CPT Code _____

ICD - 10 _____

Status Outpt AM Admit Ext OP Postop bed request: ICU PCU Duration: _____

Approved LOS _____ Authorization # _____ Referring MD _____

Clearances: Cardiology Medical Pulmonary Hematology Dates scheduled _____

Anesthesia type: TIVA Gen Spinal LMA Regional block Local

On admit insert capped IV unless anesthesia type is local.

Hang IV fluids as per anesthesia type indicated on page one. (NO IV fluids for local anesthesia):
 Start IV NSS 500 ML at KVO rate for all TIVA and Dialysis patients.
 (Nursing may adjust fluid volume to 250 ml for Dialysis patients on admission.)
 Start IV LR 1,000 ML at KVO rate for all General/Spinal/LMA/Regional block patients.

Anesthesia to administer the following block for postoperative pain relief:

Epidural TAP Cervical plexus Supraclavicular Interscalene Ankle Popliteal Femoral nerve Sciatic nerve Axillary

STUDY	Electronic EO	PRE	ON ADMIT	OK to USE	COMMENT (**done on admit)
CBC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
H/H	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	** All dialysis patients
PTT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	**On anticoagulants and scheduled for regional anesth
PT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	**On anticoagulants and scheduled for regional anesth
Type and screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Type and cross - # units	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BGM on admission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sed rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Potassium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	** All dialysis patients
UA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urine with Reflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urine culture and sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urine pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	**All female age menarche to 57 no hx of hysterectomy
Chest X ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
KUB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CT scan (MAKO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EKG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Savi Loc		<input type="checkbox"/>			<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT
Sentinel Node Biopsy	<input type="checkbox"/> Isotope <input type="checkbox"/> Mapping <input type="checkbox"/> Lymphadema prevention				
Needle Localization	<input type="checkbox"/> Imaging guidance (TBD by Radiologist) <input type="checkbox"/> MRI guidance				

Physician Signature _____ Date _____ Time _____



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Weight (kg) _____ *****Patient weight is required to prevent delays with pre-operative orders*****

VTE prophylaxis Thigh hi TEDS Knee Hi TEDS Foot Pumps Compression Devices

ANTIBIOTICS - ADMINISTER ACCORDING TO SCIP CRITERIA

Allergies: _____

- Cefazolin 2 g IV preop (for patients less than 120 kg) Cefazolin OK to give with history of Penicillin allergy
- Cefazolin 3 g IV preop (for patients equal to or more than 120 kg)
- Cefazolin (Pediatric): _____ mg (30 mg/kg) IV preop
- Metronidazole (Flagyl) _____ mg IV Preop
- Ampicillin _____ mg IV preop
- Gentamicin _____ mg IV preop
- Cefepime (Maxipime) _____ gram IV preop
- Levofloxacin (Levaquin) _____ mg IV preop
- Vancomycin _____ 15 mg/kg IV preop for adult patients (Pharmacy to dose and round up to nearest 250 mg prior to surgery. Max dose 2 grams. SPU staff to weigh patient on arrival.)
- Vancomycin _____ mg IV preop (for pediatric patients)
- Other _____

ANTICOAGULANTS - ADMINISTER ACCORDING TO ANESTHESIA DIRECTION

Heparin _____ units subcutaneous preop (hold until after epidural per anesthesia)

Enoxaparin (Lovenox) _____ mg subcutaneous preop (hold until after epidural per anesthesia)

OTHER:

- Emla cream (Ela-max) and tegaderm to _____ on arrival
- Scopolamine (Transderm Scop) 1.5 mg patch - apply preop
- Intraoperative sinus flush: dispense to OR **Vancomycin** 100 mg in 10 ml 0.9% NSS
- Vein ablation surgery: Dispense to OR **Tumescent Solution: 500 ml NSS with 50 ml Lidocaine 1% with Epinephrine 1:100,000 and 5 mEq Sodium Bicarbonate 8.4%**
- SPU nurse to instruct the patient in the following for the day of surgery: Continue Beta Blockers, cardiac medications, anti-seizure medications, anti-reflux medications, inhalers and pain medication - take with a small sip of water; Hold ACE/ARB medications if spinal or general anesthesia; Hold diuretics; Hold antidiabetic medications if NPO; Hold herbal medications. **Notify surgeon if patient did not follow instructions regarding anticoagulants.**

ADDITIONAL ORDERS:

Physician Signature _____ Date _____ Time _____

