

Patient Name _____ DOB _____

Procedure/Date _____ Height _____ Weight _____

PREP ORDERS

<input type="checkbox"/> No pre-procedure testing needed	Hematology	Misc Labs	Cardiac Studies
<input type="checkbox"/> Pre-procedure testing obtained or to be obtained at other site Where? _____	<input type="checkbox"/> CBC with Differential	<input type="checkbox"/> Carcinoembryonic Ag (CEA)	<input type="checkbox"/> EKG 12 Lead
Blood Bank	<input type="checkbox"/> CBC w/o Differential	<input type="checkbox"/> Creatine Kinase	<input type="checkbox"/> O2 Saturation
<input type="checkbox"/> Blood Type and Screen (ESP)	<input type="checkbox"/> INR	<input type="checkbox"/> C-reactive Protein	Misc Orders - Please Describe:
Chemistry	Urine	<input type="checkbox"/> Folate Level	<input type="checkbox"/> Other _____
<input type="checkbox"/> Basic metabolic panel	<input type="checkbox"/> Urinalysis Reflux, with sediment (Culture if positive)	<input type="checkbox"/> Hemoglobin A1C	<input type="checkbox"/> Other _____
<input type="checkbox"/> Comprehensive metabolic panel	<input type="checkbox"/> HCG, UR QI	<input type="checkbox"/> Lipid Panel non-fasting	<input type="checkbox"/> Other _____
Imaging	<input type="checkbox"/> Nicotine & Metabolites Ur	<input type="checkbox"/> Partial Thromboplastin Time	<input type="checkbox"/> MRSA Screen
<input type="checkbox"/> XR Chest PA and Lateral (NOT required by Anesthesia guidelines)	<input type="checkbox"/> POC Urine Pregnancy Test	<input type="checkbox"/> Prostate-Specific Ag Diagnostic	<input type="checkbox"/> Preoperative Consult
	<input type="checkbox"/> Culture Urine	<input type="checkbox"/> Sedimentation rate	<input checked="" type="checkbox"/> Colon Surgery Packet
		<input type="checkbox"/> Vitamin B12	<input checked="" type="checkbox"/> Hibiclens Cleanser
			<input checked="" type="checkbox"/> ClearFast

DAY OF PROCEDURE ORDERS

CODE STATUS - REQUIRED	IV Insertion, Fluid & Maintenance	Latex Allergy? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Full Code (Default)	<input checked="" type="checkbox"/> IV Insertion and Maintenance	MRSA Status
<input type="checkbox"/> Tailored Code	Intradermal 1% Lidocaine	<input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE
<input type="checkbox"/> DNR	0.1 ml for prior to intravenous insertion	<input type="checkbox"/> UNKNOWN
Point of Care Testing	<input checked="" type="checkbox"/> Lactated ringers IV	ABX Related Allergies _____
<input checked="" type="checkbox"/> POC Finger Stick Bedside Glucose	Infuse at _____ ml/hr, continuous via peripheral line (default to 50ml/hr)	_____
<input type="checkbox"/> POC Urine Pregnancy Test	<input type="checkbox"/> NaCl 0.9% IV	_____
<input type="checkbox"/> POC Urine Dipstick Analysis	Infuse at _____ ml/hr continuous via peripheral line (default to 50ml/hr)	High Risk Allergy to Beta-Lactam (cephalosporin, PCN, carbapenem)?
VTE Prophylaxis - REQUIRED	<input type="checkbox"/> Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
<input type="checkbox"/> Pharmacological consult if history of HIT	Medications	Pre-operative Prophylactic Antibiotic Protocol
<input type="checkbox"/> Heparin (porcine) injection, 5000 Units Subcutaneous, once pre-procedure	<input checked="" type="checkbox"/> Acetaminophen tablet, 1000 mg, Oral, For 1 Dose	<input type="checkbox"/> No antibiotic for preoperative day of surgery
<input type="checkbox"/> Heparin (porcine) injection, weight > 150 kg, 7500 Units Subcutaneous, once pre-procedure	<input type="checkbox"/> Celecoxib capsule, 400 mg, Oral, For 1 Dose	Utilize the following ABX algorithm:
<input type="checkbox"/> Enoxaparin injection, 40kg/m2 and CrCl>30ml/min, 40 mg, Subcutaneous, once, pre-procedure	<input checked="" type="checkbox"/> Gabapentin capsule, 300 mg, Oral, For 1 Dose	<input type="checkbox"/> <u>Clean/ Skin, Bone, Soft Tissue</u> <i>(Head, Neck, Breast, Hernia, more)</i>
<input type="checkbox"/> Apply SCD (Sequential Compression devices)	Labs (All LABS to be done STAT Day of Surgery unless otherwise indicated)	<input checked="" type="checkbox"/> <u>Clean/ Contaminated with anaerobic Coverage</u> <i>(Lower GI/Obstructed GI)</i>
<input type="checkbox"/> Apply Compression Stockings	<input type="checkbox"/> Blood TYPE and SCREEN	<input type="checkbox"/> <u>Clean/ Contaminated without anaerobic coverage</u> <i>(Upper GI/ Hepatopancreatobiliary)</i>
<input type="checkbox"/> No DVT Prophylaxis	<input type="checkbox"/> BMP	
Rationale? (check below):	<input type="checkbox"/> CMP	
<input type="checkbox"/> Low risk DVT	<input type="checkbox"/> CBC w/o diff	
<input type="checkbox"/> High Risk Bleeding	<input type="checkbox"/> INR	
<input type="checkbox"/> Platelet Count <50,000	<input type="checkbox"/> HCG UR QL	
<input type="checkbox"/> Oral Anticoagulant	<input type="checkbox"/> Other _____	
<input type="checkbox"/> INR > 2.0 secondary to Warfarin Therapy		
<input checked="" type="checkbox"/> Sage (CHG) Wipes		
<input checked="" type="checkbox"/> Bair Hugger		

Signature: _____ Date _____

Print Name _____ Time _____