Location: _____

Enhanced Recovery After Surgery (ERAS) Orders

- ☐ **ERAS Orders**
  - ☐ **ERAS Labs and Mutimodal Pain Management**
    - ☑ **ERAS Labs**
      - ☑ **Nasal Decolonization for MRSA -Select One Option:** (Required)
        - ◉ **povidone-iodine (3M SKIN AND NASAL ANTISEPTIC) 0.5% NASAL swab Dose:** 4 Swab **Route:** nasal **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
          Admin Instructions:
          Prior to Surgery: Insert swab into one nostril for 30 seconds. Using a new swab, repeat with the other nostril. Repeat the application in both nostrils using new swabs. Patient instructed not to blow nose, may dab any drainage with tissue.
        - ○ **IODINE ALLERGY ONLY: mupirocin (BACTROBAN) 2 % ointment Dose:** 1 Application **Route:** nasal **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
          Admin Instructions:
          Prior to Surgery: Apply to each nare. Patient instructed not to blow nose, may wipe any drainage with tissue.
      - ☑ **Prealbumin level Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
      - ☑ **Albumin level Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
      - ☑ **Albumin, random urine Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Urine
      - ☑ **Thyroid stimulating hormone Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
      - ☑ **Iron level Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
      - ☑ **Total iron binding capacity, percent transferrin saturation, and iron level Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
      - ☑ **Ferritin level Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
      - ☑ **Vitamin D 25 hydroxy level Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
      - ☑ **Vitamin B12 level Frequency:** Once **Frequency Limit:** 1 Occurrences **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
    - ☑ **ERAS Multimodal Pain Management - acetaminophen**
      - ○ **Patient weight LESS than or equal to 60 kg - acetaminophen (TYLENOL) tablet Dose:** 650 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
        Question(s):
        Allowance for Patient Preference:
        Product Admin Instructions:
        Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).
      - ○ **Patient weight above 60 kg - acetaminophen (TYLENOL) tablet Dose:** 1000 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
        Question(s):
        Allowance for Patient Preference:

General

Case Request

○ **LOBECTOMY, LUNG, ROBOT-ASSISTED, THORACOSCOPIC** **Frequency:** Once **Phase of Care:** Scheduling/ADT
Priority: Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

○ **LOBECTOMY, USING VATS** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

○ **EXPLORATION, CHEST, FOR POSTOPERATIVE COMPLICATION** **Frequency:** Once **Phase of Care:** Scheduling/ADT
Priority: Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

○ **BRONCHOSCOPY** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

○ **BRONCHOSCOPY, USING ELECTROMAGNETIC NAVIGATION** **Frequency:** Once **Phase of Care:** Scheduling/ADT
Priority: Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

○ **THORACOTOMY** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

○ **THORACOSCOPY** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

○ **PLEURODESIS, THORACOSCOPIC** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

○ **DEBRIDEMENT, STERNUM** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

○ **MYOTOMY, ESOPHAGUS, PERORAL, ENDOSCOPIC** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

○ **Case request operating room** **Frequency:** Once **Phase of Care:** Scheduling/ADT **Priority:** Routine
Question(s):
Requested time:
Special needs:
Add on case?
Clinical trial?
Case Classification:
PAT Needs?
Pre-op diagnosis:
CPT Codes:
ERAS?

Planned ICU Admission Post-Operatively (Admit to Inpatient Order)

Patients who are having an Inpatient Only Procedure as determined by CMS and patients with prior authorization for Inpatient Care may have an Admit to Inpatient order written pre-operatively.

☑ **Admit to Inpatient** **Frequency:** Once **Ordering Quantity:** 1 **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Admitting Physician:
Level of Care:
Patient Condition:
Bed request comments:
Certification: I certify that based on my best clinical judgment and the patient's condition as documented in the HP and progress notes, I expect that the patient will need hospital services for two or more midnights.

Nursing

Vital Signs

☑ **Vital signs - T/P/R/BP (per unit protocol)** **Frequency:** Per unit protocol **Phase of Care:** Pre-op **Priority:** Routine

Telemetry Order

☐ **Telemetry**

☑ **Telemetry monitoring** **Frequency:** Continuous **Frequency Limit:** 48 Hours **Priority:** Routine
Question(s):
Order: Place in Centralized Telemetry Monitor: EKG Monitoring Only (Telemetry Box)
Reason for telemetry:
Can be off of Telemetry for baths? Yes
Can be off for transport and tests? Yes

☑ **Telemetry additional setup information** **Frequency:** Continuous **Frequency Limit:** 48 Hours **Priority:** Routine
Question(s):
High Heart Rate (BPM): 130.000
Low Heart Rate(BPM): 50.000
High PVC's (per minute): 10.000

Activity

☑ **Activity as tolerated** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Specify: ○ Activity as tolerated

☐ **Ambulate** **Frequency:** 3 times daily **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Specify:

☐ **Bed rest** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Bathroom Privileges:

☐ **Out of bed** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Specify: ○ Out of bed

Nursing Care

☑ **Intake and output** **Frequency:** Every shift **Phase of Care:** Pre-op **Priority:** Routine

☑ **Bedside glucose** **Frequency:** Conditional Frequency **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood
Comments: Perform POC Bedside Glucose if patient has diabetes, or BMI 25 or greater, or age 45 or greater, or has an insulin pump. -If POC glucose is GREATER THAN 180 mg/DL, notify Anesthesiologist for consideration of perioperative glycemic control optimization. -if POC glucose is LESS THAN 70 mg/dL, notify anesthesiologist and activate Hypoglycemia Management for Adult Patients order set.

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

- [x] **Height and weight** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine
- [x] **5M walk test/frailty test** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Complete 5 meter gait speed test
- [ ] **Initiate and maintain IV**
  - [x] **Insert peripheral IV** **Frequency:** Once **Priority:** Routine
  - [x] **sodium chloride 0.9 % flush** **Dose:** 10 mL **Frequency:** every 12 hours scheduled **PRN Reasons:** line care
  - [x] **sodium chloride 0.9 % flush** **Dose:** 10 mL **Route:** intravenous **Frequency:** PRN **PRN Reasons:** line care
- [ ] **Provide equipment / supplies at bedside** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Clip and prep
  Question(s):
  Supplies: ○ Other (specify)
  Other: Clippers
- [ ] **Obtain medical records** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Obtain records of previous admissions and send to operating room with patient
  Question(s):
  Specify From:
- [ ] **Obtain medical records** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Please send cath film and ECHO to *** for uploading.
  Question(s):
  Specify From:

Diet

Guidelines/order for Elective Surgery Only. Guidelines/order Contraindications to allow water until 2 hours prior to scheduled surgery date/time include CURRENT: Gastroparesis, GERD, Hiatal Hernia, Pregnancy, Bowel Obstruction, and Ileus.

- [ ] **NPO-after midnight, Except medications and allow water until 2 hours prior to scheduled surgery date/time**
  Frequency: Diet effective midnight **Phase of Care:** Pre-op **Priority:** Routine
  Question(s):
  NPO: ○ Except meds
  Pre-Operative fasting options: ○ Other
  Specify: Allow water until 2 hours prior to scheduled surgery date/time
  Process Instructions:
  An NPO order without explicit exceptions means nothing can be given orally to the patient.
- [ ] **NPO** **Frequency:** Diet effective now **Phase of Care:** Pre-op **Priority:** Routine
  Question(s):
  NPO:
  Pre-Operative fasting options:
  Process Instructions:
  An NPO order without explicit exceptions means nothing can be given orally to the patient.
- [ ] **NPO-except meds** **Frequency:** Diet effective now **Phase of Care:** Pre-op **Priority:** Routine
  Question(s):
  NPO: ○ Except meds
  Pre-Operative fasting options:
  Process Instructions:
  An NPO order without explicit exceptions means nothing can be given orally to the patient.
- [ ] **NPO-after midnight** **Frequency:** Diet effective midnight **Phase of Care:** Pre-op **Priority:** Routine
  Question(s):
  NPO:
  Pre-Operative fasting options:
  Process Instructions:
  An NPO order without explicit exceptions means nothing can be given orally to the patient.

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☐ **Diet** **Frequency:** Diet effective now **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Diet(s):
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

Education

☑ **Patient education-PreOp Cardiovascular Surgery teaching** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Comments:** 1. No Smoking 2. Before surgery, walk 15-20 minutes daily. 3. Before surgery, you will learn how to perform coughing and deep breathing exercises using an incentive spirometer (IS), a tool used to help strengthen your breathing. These exercises lower the risk of lung complications after surgery. Repeat 10 times per hour while awake. 4. Bathe or shower the night before your surgery using Hibiclens soap that was provided to you to help prevent surgical site infection. Bathe or shower the morning of your surgery using Hibiclens soap. 5. After surgery, you will be moved to the intensive care unit (ICU) with a breathing tube, chest tubes and urine catheter. The breathing tube is safely removed as soon as possible. 6. After surgery, your care team will determine when you are able to sit ("dangle") on the side of the bed. Once your blood pressure, heart rate and blood circulation are stable, you will progress to sitting in a chair. Later expectations are to sit in chair for all meals and walk 4 times daily as tolerated. 7. After surgery, you will learn how to perform coughing and deep breathing exercises using an incentive spirometer (IS), a tool used to help strengthen your breathing. These exercises lower the risk of lung complications after surgery. Repeat 10 times per hour while awake. 8. After surgery, you will start out by sucking on ice chips, then advanced to drinking limited fluids. You may begin a heart healthy/low sodium diet. 9. After surgery, you will begin cardiac rehabilitation in the hospital. After you are discharge and when it is safe to participate, your physician will refer you to cardiac rehabilitation phase II. Cardiac rehab uses exercise training and lifestyle changes to optimize your physical, psychological and social functioning.
Question(s):
Education for: ○ Other (specify)
Specify: PreOp Cardiovascular Surgery teaching
Patient/Family:

☐ **Tobacco cessation education** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Per STS Adult Cardiac Surgery - Tobacco cessation should be provided to tobacco users within a year of surgery (tobacco usage with 1 year of surgery). Tobacco cessation education documentation consist of the following: Brief counseling of 3 minutes or less (documentation of minimal and intensive advice/couneling interventions conducted both in person and over the phone), AND/OR pharmacotherapy (documentation of a prescription given to patient for tobacco cessation).

Consents

☐ **Complete consent for** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Procedure:
Diagnosis/Condition:
Physician:
Risks, benefits, and alternatives (as outlined by the Texas Medical Disclosure Panel, as appears on Houston Methodist Medical/Surgical Consent forms) were discussed with patient/surrogate?

Perfusion

Cell Saver

☐ **Cell saver** **Frequency:** Until discontinued **Phase of Care:** Intra-op **Priority:** Routine

☐ **Platelet sequestration** **Frequency:** Until discontinued **Phase of Care:** Intra-op **Priority:** Routine

Cell Saver Medications

☑ **sodium chloride 0.9 % bolus** **Dose:** 1000 mL **Route:** perfusion **Frequency:** PRN **Phase of Care:** Intra-op **Minimum Infusion Duration:** 15.000 Minutes **PRN Comment:** Cell Saver

☐ **anticoagulant citrate dextrose (ACD) irrigation** **Dose:** 1000 mL **Route:** perfusion **Frequency:** PRN **Phase of Care:** Intra-op **PRN Comment:** Cell Saver
Admin Instructions:
Not for IV Use. For Extracorpeal Use ONLY. Must be given with calcium infusion.

☐ **sodium chloride 0.9 % 1,000 mL with HEParin (porcine) 5,000 Units cell saver perfusion** **Dose:** 1000 mL **Route:** perfusion **Frequency:** PRN **Phase of Care:** Intra-op **PRN Comment:** Heparinzed saline for cell saver

Medications

Surgical Prep Medications

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **Surgical Prep - chlorhexidine (HIBICLENS) 4% Surgical Scrub and chlorhexidine (PERIDEX) 0.12 % oral solution**

☑ **Night Prior to and Morning of Surgery - For Patients Who Can Shower ONLY - chlorhexidine (HIBICLENS) 4 % liquid Dose:** 4 **Route:** Topical **Frequency:** 2 times daily **Phase of Care:** Pre-op
Admin Instructions:
Please supply and instruct patient. Chlorhexidine bath/shower the night prior to surgery and the morning of surgery.

☑ **Night Prior to and Morning of Surgery - chlorhexidine (PERIDEX) 0.12 % oral solution Dose:** 5 mL **Route:** Swish & Spit **Frequency:** 2 times daily **Phase of Care:** Pre-op
Admin Instructions:
Night Prior to and Morning of Surgery

☑ **Oral Decolonization**

☑ **Pre-op Prior to Surgery (AOD), Chlorhexidine (PERIDEX) 0.12 % oral solution Dose:** 5 mL **Route:** Mouth/Throat **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
Admin Instructions:
Pre-op prior to surgery (AOD),Swish and Spit as directed.

☑ **Nasal Decolonization for MRSA -Select One Option:** (Required)

◉ **povidone-iodine (3M SKIN AND NASAL ANTISEPTIC) 0.5% NASAL swab Dose:** 4 Swab **Route:** nasal **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
Admin Instructions:
Prior to Surgery: Insert swab into one nostril for 30 seconds. Using a new swab, repeat with the other nostril. Repeat the application in both nostrils using new swabs. Patient instructed not to blow nose, may dab any drainage with tissue.

○ **IODINE ALLERGY ONLY: mupirocin (BACTROBAN) 2 % ointment Dose:** 1 Application **Route:** nasal **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
Admin Instructions:
Prior to Surgery: Apply to each nare. Patient instructed not to blow nose, may wipe any drainage with tissue.

☐ **metoprolol tartrate (LOPRESSOR) tablet Dose:** 12.5 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
Question(s):
BP & HR HOLD parameters for this order: ○ Hold Parameters requested
HOLD for Heart Rate LESS than: 50 bpm
Contact Physician if:

☐ **Surgical Prophylaxis Antibiotics: For Patients LESS than or EQUAL to 100 kg**

○ **Standard Surgical Prophylaxis: cefazolin (ANCEF) IV +/- vancomycin IV**

☑ **Cefazolin 2 g**

☑ **ceFAZolin (ANCEF) IV Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 60 minutes of incision; On Call to OR

☐ **Vancomycin IV**

Patient Weight	Vancomycin Dose
<80 kg	1 g
80-100 kg	1.5 g
>100 kg	2 g

*Maximum pre-op dose 2 g

☑ **Weight < 80 kg**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **Weight < 80 kg Dose:** 1 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **Weight 80-100 kg**

☑ **Weight 80-100 kg Dose:** 1.5 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **Weight >100 KG**

☑ **Weight 80-100 kg Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

○ **For Patients with Cephalosporin Allergy - vancomycin + aztreonam**

☑ **Vancomycin IV**

Patient Weight	Vancomycin Dose
<80 kg	1 g
80-100 kg	1.5 g
>100 kg	2 g

*Maximum pre-op dose 2 g

☑ **Weight < 80 kg**

☑ **Weight < 80 kg Dose:** 1 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **Weight 80-100 kg**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **Weight 80-100 kg Dose:** 1.5 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **Weight >100 KG**

☑ **Weight 80-100 kg Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **aztreonam (AZACTAM) IV Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:

☐ **Surgical Prophylaxis Antibiotics: For Patients GREATER than 100 kg**

○ **Standard Surgical Prophylaxis: cefazolin (ANCEF) IV +/- vancomycin IV**

☑ **Cefazolin 3 g**

☑ **ceFAZolin (ANCEF) IV Dose:** 3 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 60 minutes of incision; On Call to OR

☐ **Vancomycin IV**

Patient Weight	Vancomycin Dose
<80 kg	1 g
80-100 kg	1.5 g
>100 kg	2 g

*Maximum pre-op dose 2 g

☑ **Weight < 80 kg**

☑ **Weight < 80 kg Dose:** 1 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **Weight 80-100 kg**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **Weight 80-100 kg Dose:** 1.5 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **Weight >100 KG**

☑ **Weight 80-100 kg Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

○ **For Patients with Cephalosporin Allergy - vancomycin + aztreonam**

☑ **Vancomycin IV**

Patient Weight	Vancomycin Dose
<80 kg	1 g
80-100 kg	1.5 g
>100 kg	2 g

*Maximum pre-op dose 2 g

☑ **Weight < 80 kg**

☑ **Weight < 80 kg Dose:** 1 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **Weight 80-100 kg**

☑ **Weight 80-100 kg Dose:** 1.5 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Priority: STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **Weight >100 KG**

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **Weight 80-100 kg** **Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Admin Instructions:
Administer within 120 minutes of incision; On Call to OR

☑ **aztreonam (AZACTAM) IV** **Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Per Med Staff Policy, R.Ph. will automatically renally dose this medication based on current SCr and CrCl values.:
Indication:

VTE

Labs

☐ **COVID-19 Qualitative PCR**

☐ **COVID-19 qualitative RT-PCR - Nasal Swab** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Specimen Source: Nasal Swab
Is this for pre-procedure or non-PUI assessment? ○ Yes
Specimen Source:

Laboratory

☑ **CBC with platelet and differential** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Comprehensive metabolic panel** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Prothrombin time with INR** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Partial thromboplastin time, activated** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Do not draw blood from the arm that has heparin infusion. Do not draw from heparin flushed lines. If there is no other access other than the heparin line, then stop the heparin, flush the line, and aspirate 20 ml of blood to waste prior to drawing a specimen.

☑ **Hemoglobin A1c** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Magnesium level** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Lipid panel** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Hepatic function panel** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Urinalysis screen and microscopy, with reflex to culture** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Urine
Question(s):
Specimen Source: Urine
Specimen Site:
Primary Ordering Comments:
Specimen must be received in the laboratory within 2 hours of collection.

☐ **Basic metabolic panel** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Platelet function analysis** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

☐ **Iron level** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Ferritin level** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☐ **Ionized calcium** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Deliver specimen immediately to the Core Laboratory.

☐ **Vitamin B12 level** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**

☑ **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**

☑ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

☑ **MRSA PCR has been ordered within 24 hours. Repeat testing is not indicated at this time.**
@LASTLAB(MRSAPCR)@

☐ **MRSA PCR has been ordered within 24 hours. Repeat testing is not indicated at this time.** **Frequency:** Until discontinued **Priority:** Routine

☑ **MRSA PCR has been ordered within the last 7 days. This test has shown to retain high negative predictive value within this time interval.**
@LASTLAB(MRSAPCR)@

☐ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

☑ **This patient has a positive MRSA PCR result within the last 7 days.**
@LASTLAB(MRSAPCR)@

☐ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

☑ **Methicillin-Resistant Staphylococcus aureus (MRSA), NAA**
@LASTLAB(MRSAPCR)@

☑ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Priority:** Routine **Specimen Type:** Nares

☐ **Blood gas, arterial** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3 **Comments:** If indicated for heavy smoker, COPD

Cardiology

Cardiology

☑ **ECG Pre/Post Op** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine **Maximum Quantity:** 6
Question(s):
Clinical Indications: ○ Pre-Op Clearance
Interpreting Physician:

☐ **Echocardiogram complete w contrast and 3D if needed** **Frequency:** 1 time imaging **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Does this study require a chemo toxicity strain protocol?
Does this exam need a strain protocol?
Call back number for Critical Findings:
Where should test be performed?
Does this exam need a bubble study?
Preferred interpreting Cardiologist or group:
Process Instructions:
If this patient has had an echocardiogram ordered/performed within the past 120 hours as indicated by repeat Echo orders report on the left. Please contact the Echo department at 713-441-2222 to discuss the reason for a repeat exam with a cardiologist.

For STAT order, select appropriate STAT Indication. Please enter the cell phone number for the ordering physician so the echo attending can communicate the results of the stat test promptly. If the phone number is not entered, we will not be able to perform the test as stat. Please note that nursing unit phone number or NP phone number do not meet this request'

Other Indications should be ordered for TODAY or Routine.

For Discharge or Observation patient, please choose TODAY as Priority.

Imaging

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

Diagnostic X-Ray

☑ **Chest 2 Vw** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Chest 1 Vw** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Is the patient pregnant?
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

Diagnostic Ultrasound

☐ **Us carotid duplex** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Start Date:** S **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Laterality:
Special protocol:

☐ **Us vein mapping lower extremity** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Start Date:** S **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Laterality:
Preferred interpreting Cardiologist or group:

Respiratory

Respiratory Therapy

☑ **Incentive spirometry instructions** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Frequency of use: ○ Establish baseline. Please supply and instruct how to use incentive spirometer and instruct to practice 10 times every hour while awake before surgery.

☐ **Bedside spirometry** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Primary Ordering Comments:
Patient should not be given a bronchodialator 4 hours before scheduled test.

☐ **Six minute walk w/ pulse oximetry** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Purpose:
RT to follow protocol for changes to requested PFT orders?

☐ **Spirometry pre & post w/ bronchodilator, diffusion, lung volumes (Full PFT)** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

☐ **Spirometry pre & post w/ bronchodilator (FEV 1 Only)** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

Blood Products

Lab Draw

☑ **Type and screen** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood

Blood Products

☐ **Red Blood Cells**

☑ **Red Blood Cells**

Antibodies are present. There may be a delay in product availability.

☑ **Prepare RBC** **Frequency:** Blood - Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine
Specimen Type: Blood
Question(s):
Transfusion Indications:
Transfusion date:

☑ **Transfuse RBC** **Frequency:** Transfusion **Start Date:** S **Priority:** Routine
Question(s):
Transfusion duration per unit (hrs):

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **sodium chloride 0.9% infusion Dose:** 250 mL **Route:** intravenous **Frequency:** continuous PRN **Minimum Infusion Rate:** 30.000 mL/hr **PRN Comment:** RBC transfusion
Admin Instructions:
Administer with blood

☑ **Red Blood Cells**

☑ **Prepare RBC Frequency:** Blood - Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Blood
Question(s):
Transfusion Indications:
Transfusion date:

☑ **Transfuse RBC Frequency:** Transfusion **Start Date:** S **Priority:** Routine
Question(s):
Transfusion duration per unit (hrs):

☑ **sodium chloride 0.9% infusion Dose:** 250 mL **Route:** intravenous **Frequency:** continuous PRN **Minimum Infusion Rate:** 30.000 mL/hr **PRN Comment:** RBC transfusion
Admin Instructions:
Administer with blood

☐ **Platelet Pheresis**

☑ **Prepare platelet pheresis Frequency:** Once **Start Date:** S **Priority:** Routine **Specimen Type:** Blood
Question(s):
Transfusion Indications:
Transfusion date:
Process Instructions:
Usual adult dose is one pheresis platelet unit. One pheresis platelet unit is equivalent to 5-6 pooled, whole blood-derived platelet units.

☑ **Transfuse platelet pheresis Frequency:** Transfusion **Start Date:** S **Priority:** Routine
Question(s):
Transfusion duration per unit (hrs):
Process Instructions:
Usual adult dose is one pheresis platelet unit. One pheresis platelet unit is equivalent to 5-6 pooled, whole blood-derived platelet units.

☑ **sodium chloride 0.9% infusion Dose:** 250 mL **Route:** intravenous **Frequency:** continuous PRN **Minimum Infusion Rate:** 30.000 mL/hr **PRN Comment:** platelet pheresis
Admin Instructions:
Administer with blood

☐ **Fresh Frozen Plasma**

☑ **Prepare fresh frozen plasma Frequency:** Once **Start Date:** S **Priority:** Routine **Specimen Type:** Blood
Question(s):
Transfusion Indications:
Transfusion date:

☑ **Transfuse fresh frozen plasma Start Date:** S **Priority:** Routine
Question(s):
Transfusion duration per unit (hrs):

☑ **sodium chloride 0.9% infusion Dose:** 250 mL **Route:** intravenous **Frequency:** continuous PRN **Minimum Infusion Rate:** 30.000 mL/hr **PRN Comment:** fresh frozen plasma
Admin Instructions:
Administer with blood

☐ **Cryoprecipitate**

☑ **Prepare cryoprecipitate Frequency:** Blood - Once **Frequency Limit:** 1 Occurrences **Start Date:** S **Priority:** Routine **Specimen Type:** Blood
Question(s):
Transfusion Indications:
Transfusion date:

☑ **Transfuse cryoprecipitate Frequency:** Transfusion **Start Date:** S **Priority:** Routine
Question(s):
Transfusion duration per unit (hrs):

Sign:_____ **Printed Name:**_____ **Date/Time:**_____

☑ **sodium chloride 0.9% infusion** **Dose:** 250 mL **Route:** intravenous **Frequency:** continuous PRN **Minimum Infusion Rate:** 30.000 mL/hr **PRN Comment:** cryoprecipitate
Admin Instructions:
Administer with blood

Consults

CV Coordinator Consult

☑ **Consult to CV Coordinator** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Reason for consult: CABG/VALVE Surgery
Reason for Consult?

Additional Orders

Sign:_____ **Printed Name:**_____ **Date/Time:**_____