Location: _____

General

Pre Anesthesia Testing Orders

The ambulatory orders in this section are specifically for Pre Anesthesia Testing. For additional PAT orders, please use 'Future Status' and 'Pre-Admission Testing Phase of Care'

☐ **Other Diagnostic Studies for PAT**

☑ **ECG Pre/Post Op** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Maximum Quantity:** 6
Question(s):
Clinical Indications:
Interpreting Physician:

☐ **ECG 12 lead** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Maximum Quantity:** 6
Question(s):
Clinical Indications:
Interpreting Physician:

☐ **XR Chest 1 Vw Portable** **Frequency:** 1 time imaging **Phase of Care:** Pre-Admission Testing **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.):

☐ **XR Chest 2 Vw** **Frequency:** 1 time imaging **Phase of Care:** Pre-Admission Testing **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.):

☐ **Pv carotid duplex** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Laterality:
Special protocol:

☐ **Us vein mapping lower extremity** **Frequency:** 1 time imaging **Priority:** Routine
Question(s):
Laterality:
Preferred interpreting Cardiologist or group:

☐ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Nares

☐ **Respiratory**

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

☐ **Spirometry, diffusion, lung volumes** **Frequency:** Once **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

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

☐ **Body Plethysmographic lung volumes** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

☐ **Spirometry** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

☐ **OP Diffusion Capacity Combination Panel**

○ **Spirometry, diffusion** **Frequency:** Once **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

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

○ **Spirometry, diffusion, lung volumes** **Frequency:** Once **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

○ **Spirometry, diffusion, MIPS/MEPS** **Frequency:** Once **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

○ **Spirometry, diffusion, lung volumes, MIPS/MEPS** **Frequency:** Once **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

○ **Spirometry pre & post w/ bronchodilator, diffusion** **Frequency:** Once **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

○ **Spirometry pre & post w/ bronchodilator, diffusion, lung volumes** **Frequency:** Once **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

○ **Spirometry pre & post w/ bronchodilator, diffusion, MIPS/MEPS** **Frequency:** Once **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

○ **Spirometry pre & post w/ bronchodilator, diffusion, lung volumes, MIPS/MEPS** **Frequency:** Once **Priority:** Routine
Question(s):
RT to follow protocol for changes to requested PFT orders?

☐ **Laboratory: Preoperative Testing Labs**

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

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

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

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

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

☐ **Partial thromboplastin time** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **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.

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

☐ **Platelet function analysis** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **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.

☐ **Hemoglobin A1c** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Type and screen** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood

☐ **hCG qualitative, serum screen** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

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

☐ **POC pregnancy, urine** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Urine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Urinalysis, automated with microscopy** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Urine
Primary Ordering Comments:
Specimen must be received in the laboratory within 2 hours of collection.

☐ **Laboratory: Additional Labs**

☐ **Urinalysis screen and microscopy, with reflex to culture** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **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.

☐ **CBC hemogram** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
CBC only; Does not include a differential

☐ **HIV 1/2 antigen/antibody, fourth generation, with reflexes** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Syphilis treponema screen with RPR confirmation (reverse algorithm)** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Acute viral hepatitis panel (HAV, HBV, HCV)** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Thromboelastograph - NOT HMW HMSL HMB HMWB** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Anticoagulant Therapy:
Diagnosis:
Fax Number (For TEG Graph Result):
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

☐ **Thromboelastograph - HMW HMSL HMB HMWB** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **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.

☐ **Vitamin D 25 hydroxy level** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Methicillin-resistant staphylococcus aureus (MRSA), NAA** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Nares

☐ **T3** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **T4** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Thyroid stimulating hormone** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Prostate specific antigen** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **Laboratory: Additional for Bariatric patients**

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

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

☑ **hCG qualitative, serum screen** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☑ **Total iron binding capacity, percent transferrin saturation, and iron level** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **T4, free** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Thyroid stimulating hormone** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☑ **Parathyroid hormone** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

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

☑ **Partial thromboplastin time, activated** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **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.

☑ **Vitamin A level, plasma or serum** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

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

☑ **Vitamin D 25 hydroxy level** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Copper level, serum** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

☑ **Folate level** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Vitamin B1 (thiamine)** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

☑ **Zinc level, serum** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
This order is a send-out test and will have a long turnaround time, perhaps days. For information about this specific test, please call 713-441-1866 Monday-Friday, 8 am-6 pm.

Case Request

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

○ **DEBRIDEMENT, LOWER EXTREMITY** **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** **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, TRUNK** **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?

○ **REVISION, RECONSTRUCTION, BREAST** **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?

○ **RECONSTRUCTION, BREAST, WITH DIEP SKIN FLAP** **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:**_____

○ **BIOPSY, BREAST, WITH NEEDLE LOCALIZATION** **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?

○ **INCISIONAL BIOPSY, BREAST** **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?

○ **MAMMOPLASTY, REDUCTION** **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?

○ **CAPSULECTOMY, BREAST, WITH IMPLANT REMOVAL** **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?

○ **MASTOPEXY** **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:**_____

○ **ABDOMINOPLASTY** **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?

○ **MASTECTOMY, SIMPLE** **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?

○ **MASTECTOMY, MODIFIED RADICAL OR SIMPLE** **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?

○ **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

☐ **Pulse oximetry** **Frequency:** Daily **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Current FIO2 or Room Air:

Activity/Positioning

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

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

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

Nursing Care

☑ **Height and weight** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

☐ **Straight cath** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

☐ **Insert and maintain Foley**

☑ **Insert Foley catheter** **Frequency:** Once **Priority:** Routine
Question(s):
Type:
Size:
Urinometer needed:
Indication:
Primary Ordering Comments:
Foley catheter may be removed per nursing protocol.

☑ **Foley Catheter Care** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Orders: Maintain

☐ **Nasogastric tube insert and maintain**

☑ **Nasogastric tube insertion** **Frequency:** Once **Priority:** Routine
Question(s):
Type:

☐ **Nasogastric tube maintenance** **Frequency:** Until discontinued **Priority:** Routine
Question(s):
Tube Care Orders:

☐ **Apply warming blanket** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine

☐ **Bedside glucose** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Comments:** Notify MD for blood glucose less than 70 and greater than 180

☐ **Limb precautions** **Frequency:** Continuous **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Location:
Precaution:

☐ **Do not apply Mepilex** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine

☑ **Confirm NPO Status** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine

☑ **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?

☐ **Patient education- Scopolamine patch side effect teaching** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Education for: ○ Other (specify)
Specify: Scopolamine patch side effect teaching
Patient/Family:

Notify Physician

☑ **Notify Physician if current oral intake status could potentially delay procedure start time** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine **Comments:** if current oral intake status could potentially delay procedure start time

Diet

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

☐ **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-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.

☐ **NPO- Except sips with meds** **Frequency:** Diet effective now **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
NPO: ○ Except Sips with meds
Pre-Operative fasting options:
Process Instructions:
An NPO order without explicit exceptions means nothing can be given orally to the patient.

☐ **Oral supplements - Ensure Clear** **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Can/Bottle Supplements: Ensure Clear
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:
Can/Bottle Supplements:

IV Fluids

Insert and Maintain IV

☑ **Initiate and maintain IV**

☑ **Insert peripheral IV** **Frequency:** Once **Priority:** Routine

☑ **sodium chloride 0.9 % flush** **Dose:** 10 mL **Frequency:** every 12 hours scheduled **PRN Reasons:** line care

☑ **sodium chloride 0.9 % flush** **Dose:** 10 mL **Route:** intravenous **Frequency:** PRN **PRN Reasons:** line care

IV Bolus

○ **sodium chloride 0.9 % bolus 500 mL** **Dose:** 500 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Minimum Infusion Duration:** 15.000 Minutes

○ **sodium chloride 0.9 % bolus 1000 mL** **Dose:** 1000 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Minimum Infusion Duration:** 30.000 Minutes

○ **lactated ringer's bolus 500 mL** **Dose:** 500 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Minimum Infusion Duration:** 15.000 Minutes

○ **lactated ringers bolus 1000 mL** **Dose:** 1000 mL **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Minimum Infusion Duration:** 30.000 Minutes

Maintenance IV Fluids

○ **sodium chloride 0.9 % infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op

○ **lactated Ringer's infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op

○ **dextrose 5 % and sodium chloride 0.45 % with potassium chloride 20 mEq/L infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op

○ **sodium chloride 0.45 % infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op

○ **sodium chloride 0.45 % 1,000 mL with sodium bicarbonate 75 mEq/L infusion** **Dose:** 30 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op

Medications

Beta-Blockers

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

☐ **metoprolol (LOPRESSOR) injection** **Dose:** 5 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences
Phase of Care: Pre-op
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Maximum total dose is 15 mg over a 10-15 minute period.

☐ **Surgical Prophylaxis Antibiotics: Abdominal Surgery, Bariatric (Roux-en-Y), Gastric Surgery, PEG Placement, Spleen Surgery**

○ **No**

☑ **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

☑ **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**

☑ **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

On-Q Pump

○ **ropivacaine 0.2% (PF) (NAROPIN) solution for On-Q Pump Route:** infiltration **Frequency:** continuous **Phase of Care:** Pre-op
Question(s):
Continuous Rate: ○ 6 mL/hr
Regional Block:
Location:
Catheter:
Bolus Dose (Optional):
Product Admin Instructions:
This is a disposable, single-use product for Regional Block use. Do NOT refill

○ **ropivacaine 0.5% (PF) (NAROPIN) solution for On-Q Pump Route:** infiltration **Frequency:** continuous **Phase of Care:** Pre-op
Question(s):
Continuous Rate: ○ 6 mL/hr
Regional Block:
Location:
Catheter:
Bolus Dose (Optional):
Product Admin Instructions:
This is a disposable, single-use product for Regional Block use. Do NOT refill

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:

Labs

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

☐ **Basic metabolic panel 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

☐ **Partial thromboplastin time 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.

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

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

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

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

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

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

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

☐ **Pregnancy, urine** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Urine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **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.

Labs

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

☐ **Basic metabolic panel** **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

☐ **Partial thromboplastin time** **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.

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

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

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

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

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

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

☐ **Pregnancy, urine** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Urine
Question(s):
Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):

☐ **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.

☐ **Thromboelastograph** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Question(s):
Anticoagulant Therapy:
Diagnosis:
Fax Number (For TEG Graph Result):
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

☐ **Thromboelastograph** **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.

Cardiology

Cardiology

☐ **ECG 12 lead** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Maximum Quantity:** 6
Question(s):
Clinical Indications:
Interpreting Physician:

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

☐ **CV pacemaker defib or ilr interrogation** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine

Imaging

X-Ray

☐ **Chest 1 Vw Portable** **Frequency:** 1 time imaging **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.):

☐ **XR Abdomen 1 Vw Portable** **Frequency:** 1 time imaging **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.):

Other Studies

Neurophysiology

☐ **Intraoperative monitoring** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Procedure:
O.R. Location:
Modality:

Respiratory

Respiratory

☐ **Oxygen therapy** **Frequency:** Continuous **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Initial Device: ○ Nasal Cannula
Titrate FiO2 to keep O2 Sat Above: 90%
Indications for O2 therapy: ○ Other
Specify: Pre-op
Initial Rate in liters per minute: 2 Lpm
Device:
SpO2 Goal:
SpO2 Goal:
Titrate FiO2 to keep O2 saturations:
Notify Physician if:
Indications for O2 therapy:
Primary Ordering Comments:
@CERMSG(661071:25704)@

Rehab

Consults

Ancillary Consults

☐ **Consult to Case Management** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Consult Reason:
Reason for Consult?
Process Instructions:
If Ordering IV antimicrobial therapy, an additional consult to Case Management OPAT order is needed.

☐ **Consult to Social Work** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Reason for Consult:
Reason for Consult?

☐ **Consult PT eval and treat** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Reasons for referral to Physical Therapy (mark all applicable):
Are there any restrictions for positioning or mobility?
Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):
Weight Bearing Status:
Reason for PT?
Process Instructions:
If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting physical therapy

If the patient currently has an order for bed rest, please consider revising the activity order to accommodate therapy

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

☐ **Consult to PT Wound Care Eval and Treat** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Special Instructions:
Location of Wound?
Reason for PT?

☐ **Consult OT eval and treat** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Reason for referral to Occupational Therapy (mark all that apply):
Are there any restrictions for positioning or mobility?
Please provide safe ranges for HR, BP, O2 saturation(if values are very abnormal):
Weight Bearing Status:
Reason for OT?
Process Instructions:
If the patient is not medically/surgically stable for therapy, please obtain the necessary clearance prior to consulting occupational therapy

If the patient currently has an order for bed rest, please consider revising the activity order to accommodate therapy.

☐ **Consult to Nutrition Services** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Reason For Consult?
Purpose/Topic:
Reason for Consult?

☐ **Consult to Spiritual Care** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Reason for consult?
Reason for Consult?
Process Instructions:
For requests after hours, call the house operator.

☐ **Consult to Speech Language Pathology** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Reason for consult:
Reason for SLP?

☐ **Consult to Wound Ostomy Care nurse** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Reason for consult:
Reason for consult:
Reason for consult:
Reason for consult:
Consult for NPWT:
Reason for consult:
Reason for consult:
Reason for Consult?
Process Instructions:
This is NOT for PT Wound Care Consult order.

☐ **Consult to Respiratory Therapy** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Reason for Consult?
Reason for Consult?

Additional Orders

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