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:**_____

○ **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

Activity

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

☐ **Strict bed rest** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine

☐ **Activity as tolerated; up in chair** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Specify: ○ Activity as tolerated ○ Up in chair

Nursing

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

☐ **Height and weight** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine

☐ **Intake and output** **Frequency:** Every shift **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

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

☐ **Nursing to confirm perioperative antibiotics** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine
Comments: Nursing to confirm perioperative antibiotics are to be started in the periop or preop environment to be given within 1 hour prior to the incision.

☐ **NOTIFY PHARMACY ON PATIENT ARRIVAL FOR RELEASE OF CYTALUX PREPARATION** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** STAT **Comments:** Nursing to notify Pharmacy on Patient Arrival for release of CYTALUX preparation at least 1 hour prior to infusion

☐ **Incentive spirometry instructions** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Send incentive spirometer to ICU when patient leaves for operating room.
Question(s):
Frequency of use: ○ 4 times daily.

☐ **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?

Diet

☐ **NPO** **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** **Frequency:** Diet effective now **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Nothing by mouth after midnight before surgery except for cardiac and antihypertensive medications.
Question(s):
NPO:
Pre-Operative fasting options:
Process Instructions:
An NPO order without explicit exceptions means nothing can be given orally to the patient.

☐ **Diet** **Frequency:** Diet effective now **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Diet(s): ○ Other Diabetic/Cal
Consistent Carbohydrate: 1800 Kcal/225 gm Carbohydrate
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

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

☐ **Diet** **Frequency:** Diet effective now **Priority:** Routine
Question(s):
Diet(s): ○ Regular
Cultural/Special:
Cultural/Special:
Other Options:
Other Options:
Advance Diet as Tolerated?
IDDSI Liquid Consistency:
Fluid Restriction:
Foods to Avoid:
Foods to Avoid:

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

IV Fluids

IV Fluids

- ○ **sodium chloride 0.9 % infusion Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op
- ○ **lactated Ringer's infusion Dose:** 75 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:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op
- ○ **sodium chloride 0.45 % infusion Dose:** 75 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:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op

Medications

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**
  - ☑ **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

○ **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**

☑ **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

Surgical Prophylaxis Antibiotics: For Patients GREATER than or equal to 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**

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

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

*Maximum pre-op dose 2 g

- [x] **Weight < 80 kg**
  - [x] **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
- [x] **Weight 80-100 kg**
  - [x] **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
- [x] **Weight >100 KG**
  - [x] **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

○ **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

- [x] **Weight < 80 kg**
  - [x] **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
- [x] **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

Medications

☐ **mupirocin (BACTROBAN) 2 % nasal ointment Dose:** 1 Application **Route:** nasal **Frequency:** once **Frequency Limit:** 1 Occurrences **Start Date:** S **Start Time:** 2100 **Phase of Care:** Pre-Procedure
Admin Instructions:
Swab in both nostrils the night before surgery

☐ **mupirocin (BACTROBAN) 2 % nasal ointment Dose:** 1 Application **Route:** nasal **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-Procedure
Admin Instructions:
In operating room holding area. Swab in both nostrils.

Pafolacianine (CYTALUX) - for Patients with Lung Cancer/Lung Nodules ONLY

○ **pafolacianine (CYTALUX) panel - Lung Cancer/Lung Nodules**
Counsel patient to discontinue folate, folic acid or folate-containing supplements (e.g. multivitamins) 48 hours prior to pafolacianine (CYTALUX) administration.

☑ **diphenhydrAMINE (BENADRYL) injection Dose:** 25 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
Admin Instructions:
Administer 30 minutes prior to pafolacianine (CYTALUX) infusion. To be given pre-op

☑ **ondansetron (ZOFRAN) IV Dose:** 8 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
Admin Instructions:
Administer 30 minutes prior to pafolacianine (CYTALUX) infusion. Total max dose 32 mg in 24 hours including orders for other routes of administration. To be given pre-op
Product Admin Instructions:
May cause QTc prolongation.

☑ **pafolacianine (CYTALUX) 0.025 mg/kg in dextrose 5% 250 mL injection Dose:** 0.025 mg/kg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Minimum Infusion Rate:** 250.000 mL/hr **Minimum Infusion Duration:** 60.000 Minutes
Question(s):
Pafolacianine (Cytalux®) is restricted to thoracic surgery or gyn/onc physicians. Are you a thoracic surgery or gyn/onc physician or ordering on behalf of one?
Pafolacianine (Cytalux®) is restricted to the treatment of known or highly suspected lung or ovarian cancer. Do you attest that these restrictions for Cytalux (pafolacianine) have been met?
Pafolacianine (Cytalux®) is restricted to use in outpatients patients with prior financial approval. Do you attest that the patient meets this restriction?
Pafolacianine (Cytalux®) is restricted to patients that have not received any medications containing folic acid in the 48 hours prior to administration. Do you attest that the patient meets this restriction?
Admin Instructions:
ALERT O.R. PHARMACIST WHEN PATIENT HAS ARRIVED. Lung Cancer: Administer 1-24 hours prior to surgery. Ovarian Cancer: Administer 1-9 hours prior to surgery. Administer over 60 minutes using a dedicated infusion line.

VTE

Labs

☐ **COVID-19 Qualitative PCR**

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

☐ **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

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

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

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

☐ **CBC with platelet and differential** **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

☐ **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

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

☐ **hCG qualitative, 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.

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

Cardiology

Imaging

Diagnostic X-Ray

☐ **Chest 1 Vw** **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.):

☐ **Chest Pa Lateral W Fluoroscopy** **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

Other Diagnostics

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

Respiratory

Blood Products

Lab Draw

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

☑ **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):

☑ **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):

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:** 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):

☑ **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

Rehab

Consults

For Physician Consult orders use sidebar

Consults

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

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

Additional Orders

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