Location: _____

Enhanced Recovery After Surgery (ERAS) Orders

☐ **ERAS Preop Diet/Nutrition and Multimodal Pain/Chemical Prophylaxis**

☐ **ERAS Diet Prior to Day of Surgery**

Preop Clear Liquids and Carb Loading Guide for Providers (\\epic-nas.et0922.epichosted.com\static\OrderSets\ERAS Nutrition Preop Clear Liquids and Carb Loading_A Guide for HCPs_.pdf)

Preop Immunonutrition Guide for Providers (\\epic-nas.et0922.epichosted.com\static\OrderSets\ERAS Nutrition Preop Immunonutrition_A Guide for HCPs 1.pdf)

☑ **NPO/Water/Clear Liquid/Other**

○ **NPO After midnight** **Frequency:** Until discontinued **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Comments:** Nothing by mouth after midnight prior to surgery unless otherwise stated regarding ERAS nutrition.

○ **Water allowed two (2) hours prior to arrival** **Frequency:** Until discontinued **Phase of Care:** Pre-Admission Testing **Priority:** Routine

○ **Clear liquid diet** **Frequency:** Until discontinued **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Comments:** Patients can have clear liquids starting six hours prior to surgery and up until two hours before hospital arrival time only if they do not have the following contraindicated conditions or unless otherwise instructed. If a patient has any of the following conditions, they should have nothing by mouth at least six hours prior to surgery: Gastroparesis, GERD, Hiatal hernia, History of or undergoing partial or total gastrectomy, History of difficult airway, Pregnancy, Bowel obstruction, Ileus, History of difficulty swallowing (i.e. Achalasia), Neurological disorders (i.e. Parkinson's), Recent history of taking GLP-1 agonists, Hyponatremia. Clear liquids are transparent, "see-through" liquids, not cloudy or opaque, and free of pulp, bits of food, or cream. Clear liquids include, but are not limited to: Water or ice chips, Transparent fruit juices WITHOUT pulp (i.e. apple, cranberry, grape). Black or green tea WITHOUT milk or cream, Black coffee WITHOUT milk or cream. Avoid fruit juice or adding sugar to coffee/tea if patient has diabetes. Clear liquids should not alcohol.

○ **Other nutritional instructions** **Frequency:** Until discontinued **Phase of Care:** Pre-Admission Testing **Priority:** Routine

☑ **Immunonutrition and/or Carbohydrate Loading Drink**

Patient may obtain nutrition drinks at PAT appointments free of charge. If no PAT appointment planned, patient can purchase nutrition drinks out of pocket at the websites listed below."

☐ **Immunonutrition supplement** **Frequency:** Twice daily with meals (breakfast, lunch) **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Comments:** Drink one carton (8/45 oz/250 mL) of the immunonutrition supplement by mouth two times daily with meals starting five days before surgery for a total of 10 cartons. Drink last two cartons with meals on the day before surgery unless otherwise specified by surgeon. If no PAT appointment planned, patient can obtain product from Nestle's website https://www.nestlenutritionstore.com/impact-advanced-recoveryr.html. Contraindications: Renal failure with or without dialysis, Galactosemia deficiency, Congenital milk protein allergy, Allergy to fish oil or fish products (fish oil in product is derived from anchovies and sardines). Not for use when immunosuppression is desired or in patients undergoing surgery to remove breast cancer (potential for harm, not well studied). Use in breast reconstruction surgery (with flaps) has been better studied and is recommended as the beneficial effects on wound healing outweigh any potential risks.
Question(s):
Can/Bottle Supplements: Impact Advanced Recovery

☐ **Carbohydrate loading drink** **Frequency:** Conditional Frequency **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Comments:** Drink two bottles (each 10 oz/296 mL) of the clear carbohydrate drink on the night before surgery between dinner and bedtime. Finish drinking them at least one hour prior to bedtime. Drink one bottle (10 oz/296 mL) the morning of surgery at least two hours before your scheduled arrival time to the hospital. If no PAT appointment planned, patient can obtain product from Abbott's website, https://ensure.com/nutrition-products/ensure-pre-surgery. Surgical patients may have carbohydrate loading as directed if ordered by their surgeon, with anesthesiologist approval, provided they do not have any of the conditions listed: GERD, Ileus, Pregnancy, Gastroparesis, Hiatal Hernia, Hyponatremia, GLP-1 Agonists, Type 1 Diabetes, History of Uncontrolled Type 2 Diabetes (HbA1c >8), Bowel Obstruction, History of Difficult Airway, Difficulty Swallowing (Achalasia), Neurological Disorders (Parkinson's), Fluid restrictions (patients with Ascites, CHF, ESRD), Patients with history of or undergoing planned partial or total gastrectomy.
Question(s):
Can/Bottle Supplements: Ensure PreSurgery Clear Carbohydrate Drink

☐ **ERAS Diet/Nutrition Preop**

Be mindful of duplicating diet orders already in your pre-op order set.

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

Preop Clear Liquids and Carb Loading Guide for Providers (\\epic-nas.et0922.epichosted.com\static\OrderSets\ERAS Nutrition Preop Clear Liquids and Carb Loading_A Guide for HCPs_.pdf)
Preop Immunonutrition Guide for Providers (\\epic-nas.et0922.epichosted.com\static\OrderSets\ERAS Nutrition Preop Immunonutrition_A Guide for HCPs 1.pdf)

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

- ☐ **Carbohydrate loading drink** **Frequency:** Conditional Frequency **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Must consume at least two hours prior to Surgery/Procedure. Surgical patients may have carbohydrate loading as directed if ordered by their surgeon, with anesthesiologist approval, provided they do not have any of the conditions listed: GERD, Ileus, Pregnancy, Gastroparesis, Hiatal Hernia, Hyponatremia, GLP-1 Agonists, Type 1 Diabetes, History of Uncontrolled Type 2 Diabetes (HbA1c >8), Bowel Obstruction, History of Difficult Airway, Difficulty Swallowing (Achalasia), Neurological Disorders (Parkinson's), Fluid restrictions (patients with Ascites, CHF, ESRD), Patients with history of or undergoing planned partial or total gastrectomy.
  Question(s):
  Can/Bottle Supplements: Ensure PreSurgery Clear Carbohydrate Drink

- ☐ **Allow water until 2 hours before surgery.** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine

- ☑ **ERAS Nutrition Supplements (For Patients currently Admitted)**

  - ☑ **Immunonutrition and/or Carbohydrate Loading Drink**

    - ☐ **Immunonutrition supplement** **Frequency:** Twice daily with meals (breakfast, lunch) **Frequency Limit:** 5 Days **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Drink one carton (8/45 oz/250 mL) of the immunonutrition supplement by mouth two times daily with meals starting five days before surgery for a total of 10 cartons. Drink last two cartons with meals on the day before surgery unless otherwise specified by surgeon. Contraindications: Renal failure with or without dialysis, Galactosemia deficiency, Congenital milk protein allergy, Allergy to fish oil or fish products (fish oil in product is derived from anchovies and sardines). Not for use when immunosuppression is desired or in patients undergoing surgery to remove breast cancer (potential for harm, not well studied). Use in breast reconstruction surgery (with flaps) has been better studied and is recommended as the beneficial effects on wound healing outweigh any potential risks.
      Question(s):
      Can/Bottle Supplements: Impact Advanced Recovery

    - ☐ **Carbohydrate loading drink** **Frequency:** Conditional Frequency **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Drink two bottles (each 10 oz/296 mL) of the clear carbohydrate drink on the night before surgery between dinner and bedtime. Finish drinking them at least one hour prior to bedtime. Drink one bottle (10 oz/296 mL) the morning of surgery at least two hours before your scheduled arrival time to the hospital. Surgical patients may have carbohydrate loading as directed if ordered by their surgeon, with anesthesiologist approval, provided they do not have any of the conditions listed: GERD, Ileus, Pregnancy, Gastroparesis, Hiatal Hernia, Hyponatremia, GLP-1 Agonists, Type 1 Diabetes, History of Uncontrolled Type 2 Diabetes (HbA1c >8), Bowel Obstruction, History of Difficult Airway, Difficulty Swallowing (Achalasia), Neurological Disorders (Parkinson's), Fluid restrictions (patients with Ascites, CHF, ESRD), Patients with history of or undergoing planned partial or total gastrectomy.
      Question(s):
      Can/Bottle Supplements: Ensure PreSurgery Clear Carbohydrate Drink

☐ **ERAS Multimodal Pain and Chemical Prophylaxis**

Select one or a combination of analgesic medications for prophylaxis

- ☐ **acetaminophen (TYLENOL)**

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

○ **acetaminophen (TYLENOL) tablet 650 mg Dose:** 650 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
upon arrival to holding area
Product Admin Instructions:
Maximum of 3 grams of acetaminophen per day from all sources. (Cirrhosis patients maximum: 2 grams per day from all sources).

○ **acetaminophen (TYLENOL) tablet 1,000 mg Dose:** 1000 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
upon arrival to holding area

☐ **Celecoxib (CELEBREX) OR Ibuprofen (MOTRIN) OR Naprosyn Sodium (ALEVE) oral/enteral doses**

○ **celecoxib (CeleBREX) 200 mg Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Do not administer if CrCl < 30 mL/min
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 400 mg Dose:** 400 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 600 mg Dose:** 600 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **ibuprofen (ADVIL) 800 mg Dose:** 800 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

○ **naproxen (NAPROSYN) tablet Dose:** 375 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Allowance for Patient Preference:
Admin Instructions:
DO NOT administer if creatinine > 1 mg/dL and age GREATER than 75 years old
Product Admin Instructions:
Not recommended for patients with eGFR LESS than 30 mL/min OR acute kidney injury.

☐ **Gabapentinoids**

Consider Pregalabin/Lyrica only if unable to tolerate Gabapentin/Neurontin;
Contact physician if somnolence or drowsiness persists; Give with caution to patients 65 years of age and older and consider lower dose; Need renal dose adjustment; Do not administer if CrCl < 15 mL/min

○ **Gabapentinoids**

○ **gabapentin (NEURONTIN) capsule 300 mg (CrCl greater than or equal to 30 mL/min) Dose:** 300 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

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

○ **gabapentin (NEURONTIN) capsule 200 mg (CrCl 15-29 mL/min)** **Dose:** 200 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Contact physician if somnolence or drowsiness persists; Do not administer if CrCl <15 mL/min

○ **pregabalin (LYRICA)**

○ **pregabalin (LYRICA) capsule** **Dose:** 150 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences

○ **pregabalin (LYRICA) capsule** **Dose:** 50 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences

○ **pregabalin (LYRICA) capsule** **Dose:** 25 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences

☐ **ERAS Scopolamine Patch**
Increases risk for over-sedation; central anti-cholinergic side effects, including delirium

☐ **scopolamine (TRANSDERM-SCOP) 1.5 mg patch (1 mg over 3 days)** **Dose:** 1 patch **Route:** transdermal **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
Remove in 72 hours; apply upon arrival to holding area
Do not give for patients EQUAL TO or GREATER than 65 years old OR has history of prostate disease or glaucoma.

☐ **Chemical Prophylaxis**

○ **enoxaparin (LOVENOX) injection 40 mg** **Dose:** 40 mg **Route:** subcutaneous **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **enoxaparin (LOVENOX) injection 30 mg (CrCl < 30mL/min)** **Dose:** 30 mg **Route:** subcutaneous **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

○ **HEParin (porcine) injection** **Dose:** 5000 Units **Route:** subcutaneous **Frequency:** once **Frequency Limit:** 1 Occurrences

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.):

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

☐ **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?

○ **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?

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

☐ **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.):

☐ **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

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

☐ **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**

☑ **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

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

☑ **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

○ **CHOLECYSTECTOMY, LAPAROSCOPIC** **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?

○ **CHOLECYSTECTOMY, LAPAROSCOPIC, WITH POSSIBLE CHOLANGIOGRAPHY** **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:**_____

○ **APPENDECTOMY, LAPAROSCOPIC** **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?

○ **LAPAROTOMY, EXPLORATORY** **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?

○ **LAPAROSCOPY, DIAGNOSTIC** **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?

○ **REPAIR, HERNIA, INGUINAL** **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?

○ **REPAIR, HERNIA, INGUINAL, LAPAROSCOPIC, ROBOT-ASSISTED** **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:**_____

○ **REPAIR, HERNIA, INCISIONAL OR VENTRAL** **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?

○ **EXCISION, MASS** **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?

○ **GASTRECTOMY, SLEEVE, LAPAROSCOPIC** **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, NECK, WITH PARATHYROIDECTOMY** **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?

○ **GASTROENTEROSTOMY, ROUX-EN-Y, LAPAROSCOPIC, WITH INTRAOPERATIVE ENDOSCOPY** **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:**_____

○ **MASTECTOMY, PARTIAL** **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

☐ **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.

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

☑ **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

☐ **POCT 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 or greater than 180

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

☑ **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?

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

☐ **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.

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

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

○ **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

Buffered Lidocaine - HMH

☑ **lidocaine 1% buffered with 8.4% sodium bicarbonate(1 mL) injection Dose:** 0.5 mL **Route:** subcutaneous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
Admin Instructions:
May use up to 0.5 milliters for comfort, PreOp use only.

Lidocaine - Non HMH

☐ **lidocaine PF (XYLOCAINE) 10 mg/mL (1%) injection Dose:** 0.5 mL **Route:** subcutaneous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
Admin Instructions:
May use up to 0.5 milliters for comfort, PreOp use only.

Beta-Blockers

☐ **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.

Antiemetics

☐ **fosaprepitant (EMEND) IVPB Route:** intravenous **Frequency:** once
Question(s):
Fosaprepitant is restricted to patients receiving moderate to highly emetogenic chemotherapy, OR undergoing bariatric/foregut surgery and unable to fill an outpatient prescription for aprepitant prior to surgery. Please select the indication for use:

Surgical Prophylaxis – General Surgery (Required)

○ **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**

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

☑ **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

○ **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**

☑ **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:

○ **No Pre-Op Antibiotic is required Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

○ **Bile Duct/Liver/Pancreatic, Gallbladder, Small Bowel, or Appendix Surgery**

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

○ **Standard Prophylaxis**

○ **Surgical Prophylaxis: ceFAZolin (ANCEF) IV + metronidazole (FLAGYL) IV**

☑ **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

☑ **metronidazole (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

○ **cefoxitin (MEFOXIN) IV Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **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

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

☑ **aztreonam (AZACTAM) IV Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **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

☑ **metroNIDAZOLE (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
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

○ **No Pre-Op Antibiotic is required** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

○ **Pancreaticoduodenectomy**

○ **Standard Prophylaxis: piperacillin-tazobactam (ZOSYN) IV Dose:** 3.375 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **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

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

- [x] **aztreonam (AZACTAM) IV Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **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

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

☑ **metroNIDAZOLE (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
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**

☑ **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

○ **No Pre-Op Antibiotic is required Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

○ **Procedures needing only skin coverage (no oral/anaerobic involvement)** (Required)

○ **No**

☑ **Cefazolin 2 g**

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

☑ **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**

☑ **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

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

○ **No Pre-Op Antibiotic is required** **Frequency:** Until discontinued **Priority:** Routine

Surgical Prophylaxis – General Surgery

○ **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

○ **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:

○ **No Pre-Op Antibiotic is required Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

○ **Bile Duct/Liver/Pancreatic, Gallbladder, Small Bowel, or Appendix Surgery**

○ **Standard Prophylaxis**

○ **Surgical Prophylaxis: ceFAZolin (ANCEF) IV + metronidazole (FLAGYL) IV**

☑ **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

☑ **metronidazole (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:

○ **cefoxitin (MEFOXIN) IV Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **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

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

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

☑ **aztreonam (AZACTAM) IV Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **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

☑ **metroNIDAZOLE (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
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**

☑ **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

○ **No Pre-Op Antibiotic is required Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

○ **Pancreaticoduodenectomy**

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

○ **Standard Prophylaxis: piperacillin-tazobactam (ZOSYN) IV Dose:** 3.375 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **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

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

☑ **aztreonam (AZACTAM) IV Dose:** 2 g **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **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

☑ **metroNIDAZOLE (FLAGYL) IV Dose:** 500 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
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

○ **No Pre-Op Antibiotic is required Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

○ **Procedures needing only skin coverage (no oral/anaerobic involvement)** (Required)

○ **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**

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

○ **No Pre-Op Antibiotic is required Frequency:** Until discontinued **Priority:** Routine

VTE

DVT Prophylaxis

Please consider preoperative DVT chemoprophylaxis for patients who are not at high risk of bleeding and have one of the following: 1) Pre-existing limited mobility OR 2) Diagnosis of cancer undergoing abdominal/pelvic surgery lasting for two hours.

○ **HEParin (porcine) injection Dose:** 5000 Units **Route:** subcutaneous **Frequency:** once **Frequency Limit:** 1 Occurrences
Phase of Care: Pre-op

○ **enoxaparin (LOVENOX) injection Dose:** 40 mg **Route:** subcutaneous **Frequency:** once **Frequency Limit:** 1 Occurrences
Phase of Care: Pre-op
Question(s):
Indication(s):
Product Admin Instructions:
Administer by deep subcutaneous injection into the left and right anterolateral or posterolateral abdominal wall. Alternate injection site with each administration.

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 - HMH Only

☐ **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

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

- [ ] **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
- [ ] **Lactic acid, I-Stat, venous** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood
- [ ] **Type and screen** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood
- [ ] **POC 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.
- [ ] **PTH intraoperative** **Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **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.):
Primary Ordering Comments:
Deliver specimen immediately to the Core Laboratory.

Labs - Not HMH or HMW

- [ ] **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.

Labs - HMW Only

- [ ] **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

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

☐ **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

☐ **Lactic acid, I-Stat, venous** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood

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

☐ **POC 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.

Cardiology

Cardiology

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

☐ **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.):

Respiratory

Respiratory

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

☐ **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

☐ **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.

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

☐ **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:**_____