**Location:** _____

## General

### 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

### Vitals

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

### Nursing

☑ **Nursing communication** **Frequency:** Until discontinued **Start Date:** S **Phase of Care:** Post-op **Priority:** Routine
**Comments:** Place warming blanket on patient with body temperature of 38 degrees, if temperature is > 38 degrees hold the warming blanket for 1 hour and re-check body temperature. If temperature is < 37.5, resume warming.

☑ **Height and weight** **Frequency:** Once **Start Date:** S **Phase of Care:** Pre-op **Priority:** Routine

☑ **Place/Maintain sequential compression device continuous** **Frequency:** Continuous **Start Date:** S **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Upon arrival and in OR for prophylaxis for deep vein thrombosis
**Question(s):**
Side: Bilateral
Select Sleeve(s):

### Notify

☐ **Notify transplant liver surgery service** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Transplant Liver Surgery Service upon patient arrival to unit at phone number ****

☐ **Notify transplant hepatology service** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Transplant Hepatology Service upon patient arrival to unit at phone number ****

☑ **Notify transplant coordinator on-call** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Contact the Liver Donor Coordinator on-call upon recipient arrival or for any questions regarding transplant, 713-441-5451.

### Diet

☑ **NPO** **Frequency:** Diet effective now **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Give only specifically ordered medications
**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.

### Informed Consent

☑ **Complete consent for** **Frequency:** Once **Start Date:** S **Phase of Care:** Pre-op **Priority:** Routine
**Question(s):**
Procedure: ○ Orthotopic Liver Transplant
Diagnosis/Condition:
Physician:
Risks and Hazards:
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?

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

☐ **Complete consent for kidney transplant if patient receiving simultaneous liver and kidney transplant** **Frequency:** Once **Priority:** Routine
**Question(s):**
Procedure: ○ Liver and Kidney transplant
Diagnosis/Condition:
Physician:
Risks and Hazards:
Risks, benefits, and alternatives (as outlined by the Texas Medical Disclosure Panel, as appears on Houston Methodist Medical/Surgical Consent forms) were discussed with patient/surrogate?

**Perfusion**

**Cell Saver**

☑ **Cell saver** **Frequency:** Until discontinued **Priority:** Routine

☐ **Platelet sequestration** **Frequency:** Until discontinued **Priority:** Routine

**Cell Saver Medications**

☑ **sodium chloride 0.9 % bolus** **Dose:** 1000 mL **Route:** perfusion **Frequency:** PRN **Phase of Care:** Intra-op **Minimum Infusion Duration:** 15.000 Minutes **PRN Comment:** Cell Saver
**Question(s):**
Indication(s) for Once Reason:

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

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

**IV Fluids**

**Peripheral IV Access**

☑ **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
**Question(s):**
Indication(s) for Once Reason:

☑ **sodium chloride 0.9 % flush** **Dose:** 10 mL **Route:** intravenous **Frequency:** PRN **PRN Reasons:** line care
**Question(s):**
Indication(s) for Once Reason:

**IV Fluids**

○ **dextrose 5%-0.225% sodium chloride infusion** **Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
**Admin Instructions:**
Replace urine output with continuous IV dextrose 5% + 0.225% sodium chloride mL per mL. Replacement fluids not to exceed a maximum of 250 mL per hour and a minimum of 75 mL per hour.

○ **dextrose 5%-0.45% sodium chloride infusion** **Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
**Admin Instructions:**
Replace urine output with continuous IV dextrose 5% + 0.45% sodium chloride mL per mL. Replacement fluids not to exceed a maximum of 250 mL per hour and a minimum of 75 mL per hour.

○ **dextrose 5%-0.9% sodium chloride infusion** **Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
**Admin Instructions:**
Replace urine output with continuous IV dextrose 5% + 0.9% sodium chloride mL per mL. Replacement fluids not to exceed a maximum of 250 mL per hour and a minimum of 75 mL per hour.

○ **sodium chloride 0.45 % infusion** **Dose:** 75 mL/hr **Route:** intravenous **Frequency:** continuous **Phase of Care:** Post-op
**Admin Instructions:**
Replace urine output with continuous IV 0.45% sodium chloride mL per mL. Replacement fluids not to exceed a maximum of 250 mL per hour and a minimum of 75 mL per hour.

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

○ **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:** Post-op
**Admin Instructions:**
Replace urine output with continuous IV 0.45% sodium chloride with 75 mEq sodium bicarbonate mL per mL. Replacement fluids not to exceed a maximum of 250 mL per hour and a minimum of 75 mL per hour

**Medications**

**PreOp Antifungals**

**Select one of the following antifungals:**

○ **nystatin (MYCOSTATIN) suspension: for Lab MELD LESS THAN or EQUAL to 21**

**Select this option for patients with Lab MELD LESS THAN or EQUAL to 21**

☐ **nystatin (MYCOSTATIN) 100,000 unit/mL suspension Dose:** 5 mL **Route:** oral **Frequency:** on call to O.R. **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
**Question(s):**
Indication: ○ Surgical Prophylaxis
**Admin Instructions:**
For patients with Lab MEDS LESS than or EQUAL to 21; Swish and swallow on-call to OR.
**Product Admin Instructions:**
Swish in mouth

○ **fluconazole (DIFLUCAN) tablet: for patients with hospital stay GREATER THAN 48 hours or Lab MELD GREATER THAN 21**

**Select this option for patients in hospital GREATER THAN 48 hours or with Lab MELD GREATER THAN 21**

☐ **fluconazole (DIFLUCAN) tablet Dose:** 400 mg **Route:** oral **Frequency:** on call to O.R. **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
**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:**
If in hospital GREATER THAN 48 hours or Lab MELD GREATER THAN 21; On-call to OR with sip of water
**Product Admin Instructions:**
May cause QTc prolongation.

○ **voriconazole (VFEND) tablet: if patient in ICU or Lab MELD GREATER THAN or EQUAL to 30**

**Select this option for ICU patients or patients with Lab MELD GREATER THAN or EQUAL to 30**

☐ **voriconazole (VFEND) tablet Dose:** 200 mg **Route:** oral **Frequency:** on call to O.R. **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
**Question(s):**
Indication: Surgical Prophylaxis
Indication:
**Admin Instructions:**
If patient is in ICU or Lab MELD GREATER THAN or EQUAL to 30; On-Call to OR with sip of water.
**Product Admin Instructions:**
May cause QTc prolongation.

**PreOp Antibiotics**

**Select one of the following antibiotics:**

◉ **piperacillin-tazobactam (ZOSYN) IV: for ICU patients or patients with Lab MELD GREATER THAN 25**

**Select this option for ICU patients or patients with Lab MELD GREATER THAN 25.**

☐ **piperacillin-tazobactam (ZOSYN) IV Dose:** 3.375 g **Route:** intravenous **Frequency:** on call to O.R. **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** STAT **Minimum Infusion Duration:** 30.000 Minutes
**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 1 hour prior to skin incision; to be dispensed in Dunn OR and administered by Anesthesia.

○ **meropenem (MERREM) IV or ERTApenem (INVANZ) IV - for Penicillin Allergic patients**

**Select one of the following below for Penicillin Allergic patients.**

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

○ **meropenem (MERREM) IV Dose:** 500 mg **Route:** intravenous **Frequency:** on call to O.R. **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 1 hour prior to skin incision; to be dispensed in Dunn OR and administered by Anesthesia.

○ **ertapenem (INVanz) IV Dose:** 1 g **Route:** intravenous **Frequency:** on call to O.R. **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 1 hour PRIOR to skin incision;  To be dispensed in Dunn OR and administered by Anesthesia.
**Product Admin Instructions:**
ERTApenem must not be mixed or Y-sited into any Dextrose-containing solutions. Flush IV line with Normal Saline before and after administration.

○ **levofloxacin (LEVAQUIN) IV solution - for Penicillin Allergic Patients Dose:** 500 mg **Route:** intravenous **Frequency:** on call to O.R. **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.:
Per Med Staff Policy, R.Ph. will automatically switch IV to equivalent PO dose when above approved criteria are satisfied:
**Admin Instructions:**
Administer 1 hour prior to skin incision; to be dispensed in Dunn OR and administered by Anesthesia.
**Product Admin Instructions:**
May cause QTc prolongation.

**Section 1: Hepatitis B Prophylaxis**

☐ **hepatitis B immune globulin (HEPAGAM B) IVPB 10,000 Units Dose:** 10000 Units **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
**Admin Instructions:**
Decrease the rate to 60 mL/hr or LESS if the patient gets uncomfortable, if the patient has infusion related adverse events, or if concern about the infusion speed exists. ADMINISTER DURING THE ANHEPATIC PHASE

**Section 2: Premedications**

☑ **diphenhydrAMINE (BENADRYL) tablet Dose:** 25 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
**Admin Instructions:**
With sip of water on call to OR

☑ **acetaminophen (TYLENOL) tablet Dose:** 650 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
**Question(s):**
Allowance for Patient Preference:
Indication(s) for Once Reason:
**Admin Instructions:**
With sip of water on call to OR
**Product Admin Instructions:**
Maximum of 3 grams of acetaminophen per day from all sources.  (Cirrhosis patients maximum: 2 grams per day from all sources).

**Other Medications**

☑ **methylPREDNISolone sodium succinate (Solu-MEDROL) injection Dose:** 500 mg **Route:** intravenous **Frequency:** on call to O.R. **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op
**Admin Instructions:**
To be given in the anhepatic state; to be administered by the anesthesiologist in the OR.

**Labs**

☐ **COVID-19 Qualitative PCR**

☑ **COVID-19 qualitative RT-PCR Frequency:** STAT **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Nasal swab **Comments:** Potential transplant recipient in-house in preparation of transplant.
**Question(s):**
Is this for pre-procedure or non-PUI assessment? ○ Yes
Specimen Source:

**Labs Upon Arrival**

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

☑ **Basic metabolic panel** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

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

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

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

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

☑ **GGT** **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

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

☑ **Cytomegalovirus, quantitative PCR** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Plasma
**Question(s):**
Specimen Source: ○ Plasma

☑ **Hepatitis B virus (HBV), quantitative PCR** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Hepatitis B surface antibody** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatitis B core antibody total** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Hepatitis C virus (HCV), quantitative PCR** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☑ **Hepatitis C Virus (HCV) Antibody With Reflex to PCR** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Maximum Quantity:** 3

☑ **Epstein-Barr virus (EBV), quantitative PCR** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Maximum Quantity:** 3
**Question(s):**
Specimen Source: Plasma
Specimen Source:

☑ **HIV 1/2 antigen/antibody, fourth generation, with reflexes** **Frequency:** Once **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.):

**Laboratory - HLA**

○ **HLA antibody testing - pre transplant** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
**Primary Ordering Comments:**
Collect 1 Red Top tube (6 mL)

{HM IP HLAA LAB OPTIONS:28669}

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

◉ **HLA deceased donor** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
**Primary Ordering Comments:**
Deceased Donor Crossmatch #1 - Recipient
Collect 5 Yellow Top (10ml); 2 Red Top (10ml)
HLA Allogeneic Crossmatch (XMHLA, PXMHL, PXMH2)
HLA Auto Crossmatch (AXMHL)
{Single Antigen Bead w/wo Dil:29123}
Perform C1q? {C1q (HC1Q):29520}

Donor OPTN (UNOS ID): ***

**Microbiology**

☑ **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.

☑ **Blood culture, aerobic and anaerobic x 2**

☑ **Blood culture, aerobic and anaerobic x 2**

Most recent Blood Culture results from the past 7 days:

@LASTPROCRESULT(LAB462)@

**Blood Culture Best Practices** (https://formweb.com/files/houstonmethodist/documents/blood-culture-stewardship.pdf)

☑ **Blood culture, aerobic & anaerobic** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Comments:**
Collect before antibiotics given. Blood cultures should be drawn from a peripheral site. If unable to draw both sets from a peripheral site, please call the lab for assistance; an IV line should NEVER be used.

☑ **Blood culture, aerobic & anaerobic** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Comments:**
Collect before antibiotics given. Blood cultures should be drawn from a peripheral site. If unable to draw both sets from a peripheral site, please call the lab for assistance; an IV line should NEVER be used.

**Increased Risk for Disease Transmission Donor/Serology Testing**

☐ **Increased Risk for Disease Transmission Donor/Serology Testing**

Recommended Recipient Serological Testing Receiving Increase Risk for Disease Transmission Donors
At Time of Transplant
Baseline serological testing at time of pre-operative testing prior to transplantation performed

☐ **HIV 1/2 antigen/antibody, fourth generation, with reflexes** **Frequency:** Once **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.):

☐ **Human immunodeficiency virus 1 (HIV-1), quantitative PCR** **Frequency:** Once **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.):

☐ **Hepatitis B surface antigen** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatitis B core antibody total** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatitis B virus (HBV), quantitative PCR** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatitis C Virus (HCV) Antibody With Reflex to PCR** **Frequency:** Once **Priority:** Routine **Maximum Quantity:** 3

☐ **Hepatitis C virus (HCV), quantitative PCR** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Cytomegalovirus Ab, IgG** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Cytomegalovirus Ab, IgM** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

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

☐ **Syphilis treponema screen with RPR confirmation (reverse algorithm)** **Frequency:** Once **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.):

☐ **Increased Risk for Disease Transmission Donor/Serology Testing**

Recommended Recipient Serological Testing Receiving Increase Risk for Disease Transmission Donors At Time of Transplant
Baseline serological testing at time of pre-operative testing prior to transplantation performed

☐ **HIV 1/2 antigen/antibody, fourth generation, with reflexes** **Frequency:** Once **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.):

☐ **HIV-1 RNA, qualitative TMA** **Frequency:** Once **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.):

☐ **Hepatitis B surface antigen** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatitis B core antibody total** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatitis B virus (HBV), quantitative PCR** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Hepatitis C Virus (HCV) Antibody With Reflex to PCR** **Frequency:** Once **Priority:** Routine **Maximum Quantity:** 3

☐ **Hepatitis C virus (HCV), quantitative PCR** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Cytomegalovirus Ab, IgG** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Cytomegalovirus Ab, IgM** **Frequency:** Once **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3

☐ **Syphilis treponema screen with RPR confirmation (reverse algorithm)** **Frequency:** Once **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.):

**Imaging**

**X-Ray**

☑ **Chest 1 View Portable** **Frequency:** 1 time imaging **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** STAT
**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 Diagnostic Studies**

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

☐ **If patient has ACID or PPM, interrogate ACID/PPM** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

**Blood Products**

**Lab Draw**

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

**Blood Products**

☑ **Red Blood Cells**

☑ **Red Blood Cells**

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

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

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

☑ **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):

☑ **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:

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

☑ **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

**Additional Orders**

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