Urology Generic Pre-Op (1795)

Version: 29 **Gen:** 11/3/2026

Location: _____

General

Pre Anesthesia Testing Orders

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

☐ **Other Diagnostic Studies for PAT**

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

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

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

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

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

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

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

☐ **Respiratory**

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

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

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

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

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

☐ **OP Diffusion Capacity Combination Panel**

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

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

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

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

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

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

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

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

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

☐ **Laboratory: Preoperative Testing Labs**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ **Laboratory: Additional Labs**

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

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

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

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

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

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

☐ **Thromboelastograph - HMW HMSL HMB HMWB** **Frequency:** Once **Phase of Care:** Pre-Admission Testing **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
Primary Ordering Comments:
Specimen cannot be transported through the P-tube; hand carry specimen to the Core Laboratory.

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

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

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

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

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

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

☐ **Laboratory: Additional for Bariatric patients**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case Request

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

☐ **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 Needed?
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

☐ **Vital signs - T/P/R/BP - Every 4 Hours** **Frequency:** Every 4 hours **Phase of Care:** Pre-op **Priority:** Routine

Notify

☐ **Notify Physician for vitals:** **Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Output less than 240 mL/shift or JP output greater than 180 mL/shift
Question(s):
Temperature greater than: ○ 101.5 ○ 100.5
Systolic BP greater than: ○ 180 ○ 160
Systolic BP less than: ○ 80 ○ 90
Diastolic BP greater than: ○ 120 ○ 100
Diastolic BP less than: ○ 40 ○ 50
Heart rate greater than (BPM): ○ 115 ○ 100
Heart rate less than (BPM): ○ 45 ○ 60
Respiratory rate greater than: 25
Temperature less than:
MAP less than: 60.000
Respiratory rate less than: 8
SpO2 less than: 92

Nursing

☑ **Height and weight on arrival** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine

☑ **Complete consent form** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Procedure:
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?

☐ **Void on call to OR** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine

☐ **Verify modification of diabetic agents** **Frequency:** Until discontinued **Phase of Care:** Post-op **Priority:** Routine
Comments: Nurse to check with primary physician for diabetic medication adjustment.

☐ **Verify lab results available** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine
Comments: Nurse to verify the following labs are available: PRE-OP: CBC, INR (if on coumadin), potassium, urinalysis; Call surgeon with abnormal results

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

☐ **Verify surgical site confirmation documentation completed** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

☐ **Verify discontinuation of anti-thrombotics** **Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine **Comments:** If patient has taken any of the following agents within the listed period prior to surgery, contact surgeon for further instructions: Apixaban, aspirin, clopidogrel, rivaroxiban, dabigatran, prasugrel, or ticagrelor; 5-7 days COUMADIN/warfarin 3-5 days; enoxaparin 12 hours; and heparin 4 hours prior to procedure. If patient is taking COUMADIN/warfarin within 72 hours of exam, have INR drawn prior to appointment.

☐ **Saline lock IV** **Frequency:** Continuous **Phase of Care:** Pre-op **Priority:** Routine

☐ **Insert peripheral IV** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine

☐ **Change IV site dressing** **Frequency:** Per unit protocol **Phase of Care:** Pre-op **Priority:** Routine

☐ **Nasogastric tube insertion** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Comments:** Set to low intermittent suction.
Question(s):
Type:

☐ **Tobacco cessation education** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine

☐ **Alcohol and or drug assessment** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine

Diet

☐ **NPO - effective 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.

IV Fluids

IV Fluids

☐ **sodium chloride 0.9 % infusion** **Dose:** .9 **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op
Question(s):
Indication(s) for Once Reason:

☐ **lactated Ringer's infusion** **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op

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

☐ **dextrose 5%-sodium chloride 0.45% (D5-1/2NS) with potassium chloride (custom amount) infusion** **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op

☐ **sodium chloride 0.45% with potassium chloride (custom amount) infusion** **Route:** intravenous **Frequency:** continuous **Phase of Care:** Pre-op

Medications

Surgical Prophylaxis – Genitourinary Surgery/Urology (Required)

○ **Antibiotics - Kidney Surgery, Kidney Transplant, Prostate Surgery +/- TURP**

○ **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

○ **Gentamicin IV**

Patient Weight	Gentamicin Dose
<60 kg	320 mg
60-80 kg	400 mg
>80 kg	480 mg

*Maximum pre-op dose 480 mg

☑ **Weight < 60 kg**

☑ **gentamicin (GARAMYCIN) IVPB** **Dose:** 320 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

☑ **Weight 60 - 80 kg**

☑ **gentamicin (GARAMYCIN) IVPB** **Dose:** 400 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

☑ **Weight > 80 kg**

☑ **gentamicin (GARAMYCIN) IVPB** **Dose:** 480 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

○ **Surgical Prophylaxis**

○ **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 use in Patients with Cephalosporin Allergy - Vancomycin + Gentamicin**

☑ **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

☑ **Gentamicin IV**

Patient Weight	Gentamicin Dose
<60 kg	320 mg
60-80 kg	400 mg
>80 kg	480 mg

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

*Maximum pre-op dose 480 mg

- [x] **Weight < 60 kg**
  - [x] **gentamicin (GARAMYCIN) IVPB Dose:** 320 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
    Question(s):
    Indication: ○ Surgical Prophylaxis
    Admin Instructions:
    Administer within in 30 minutes of incision. On call to OR.
- [x] **Weight 60 - 80 kg**
  - [x] **gentamicin (GARAMYCIN) IVPB Dose:** 400 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
    Question(s):
    Indication: ○ Surgical Prophylaxis
    Admin Instructions:
    Administer within in 30 minutes of incision. On call to OR.
- [x] **Weight > 80 kg**
  - [x] **gentamicin (GARAMYCIN) IVPB Dose:** 480 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
    Question(s):
    Indication: ○ Surgical Prophylaxis
    Admin Instructions:
    Administer within in 30 minutes of incision. On call to OR.

○ **Antibiotics - Pubovaginal Sling**

○ **ceFAZolin (ANCEF) IV +/- metronidazole (FLAGYL) IV**

- [x] **No**
  - [x] **Cefazolin 2 g**
    - [x] **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
  - [x] **Cefazolin 3 g**
    - [x] **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 **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

○ **clindamycin (CLEOCIN) IV and gentamicin (GARAMYCIN) IV**

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

☑ **clindamycin (CLEOCIN) IV Dose:** 900 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis

☑ **Gentamicin IV**

Patient Weight	Gentamicin Dose
<60 kg	320 mg
60-80 kg	400 mg
>80 kg	480 mg

*Maximum pre-op dose 480 mg

☑ **Weight < 60 kg**

☑ **gentamicin (GARAMYCIN) IVPB Dose:** 320 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

☑ **Weight 60 - 80 kg**

☑ **gentamicin (GARAMYCIN) IVPB Dose:** 400 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

☑ **Weight > 80 kg**

☑ **gentamicin (GARAMYCIN) IVPB Dose:** 480 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

○ **Penile Prothesis (Insertion, Removal or Revision), Transrectal Prostate Biopsy**

○ **ceFAZolin (ANCEF) IV + gentamicin (GARAMYCIN) 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**

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

☑ **Gentamicin IV**

Patient Weight	Gentamicin Dose
<60 kg	320 mg
60-80 kg	400 mg
>80 kg	480 mg

*Maximum pre-op dose 480 mg

☑ **Weight < 60 kg**

☑ **gentamicin (GARAMYCIN) IVPB Dose:** 320 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

☑ **Weight 60 - 80 kg**

☑ **gentamicin (GARAMYCIN) IVPB Dose:** 400 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

☑ **Weight > 80 kg**

☑ **gentamicin (GARAMYCIN) IVPB Dose:** 480 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

○ **For use in Patients with Cephalosporin Allergy - Vancomycin + Gentamicin**

☑ **Vancomycin IV**

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

*Maximum pre-op dose 2 g

☑ **Weight < 80 kg**

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

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

☑ **Weight 80-100 kg**

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

☑ **Weight >100 KG**

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

☑ **Gentamicin IV**

Patient Weight	Gentamicin Dose
<60 kg	320 mg
60-80 kg	400 mg
>80 kg	480 mg

*Maximum pre-op dose 480 mg

☑ **Weight < 60 kg**

☑ **gentamicin (GARAMYCIN) IVPB** **Dose:** 320 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

☑ **Weight 60 - 80 kg**

☑ **gentamicin (GARAMYCIN) IVPB** **Dose:** 400 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 minutes of incision. On call to OR.

☑ **Weight > 80 kg**

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

☑ **gentamicin (GARAMYCIN) IVPB Dose:** 480 mg **Route:** intravenous **Frequency:** once **Frequency Limit:** 1 Occurrences **Priority:** STAT
Question(s):
Indication: ○ Surgical Prophylaxis
Admin Instructions:
Administer within in 30 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

○ **Surgical prophylaxis to be ordered outside of order set due to history of/confirmed ESBL or multi-drug resistant organisms Frequency:** Once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Priority:** Routine

Antispasmodics

☐ **belladonna alkaloids-opium (B&O SUPPRETTES) 16.2-30 mg suppository Dose:** 60 mg **Route:** rectal **Frequency:** once PRN **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **PRN Reasons:** bladder spasms
Question(s):
Allowance for Patient Preference:
Belladonna alkaloids-opium is restricted to a urology physician. Are you a urology provider or ordering on behalf of one?
Admin Instructions:
To be placed in OR prior to start of case
Product Admin Instructions:
mg dosing is based on opium component.

Beta Blocker - Required if patient is on Home Beta Blockers (Pre-Op)

If patient is on a beta blocker at home, they should receive a dose on the day of procedure unless contraindicated.

○ **Contraindication to beta blocker - patient is on a beta blocker at home, but contraindicated at this time. Frequency:** Until discontinued **Phase of Care:** Pre-op **Priority:** Routine

○ **metoprolol tartrate (LOPRESSOR) tablet Dose:** 12.5 mg **Route:** oral **Frequency:** 60 min pre-op **Frequency Limit:** 1 Occurrences **Start Date:** S **Phase of Care:** Pre-op
Question(s):
BP & HR HOLD parameters for this order:
Contact Physician if:
Admin Instructions:
Hold for systolic blood pressure less than 100 mmHg, diastolic blood pressure less than 60 mmHg, heart rate less than 50 bpm or patient is on a vassopressor or inotrope.

mitoMYcin (MUTAMYCIN) injection for TUR

!!! SELECT the TOTAL number of 10 mg/10 mL Syringes that are required !!!

☐ **mitoMYcin (MUTAMYCIN) 10 mg/10 mL syringe for TUR - select total number of syringes needed**

☑ **mitomycin (MUTAMYCIN) injection 10 mg/10 mL for TUR Dose:** 20 **Route:** injection **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
To be given in the OR for TUR - Syringe 1

☑ **mitomycin (MUTAMYCIN) injection 10 mg/10 mL for TUR Dose:** 20 **Route:** injection **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
To be given in the OR for TUR - Syringe 2

☐ **mitomycin (MUTAMYCIN) injection 10 mg/10 mL for TUR Dose:** 20 **Route:** injection **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
To be given in the OR for TUR - Syringe 3

☐ **mitomycin (MUTAMYCIN) injection 10 mg/10 mL for TUR Dose:** 20 **Route:** injection **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
To be given in the OR for TUR - Syringe 4

Chemo Bladder Instillation

○ **mitomycin (MUTAMYCIN) chemo bladder instillation**

☑ **mitoMYcin (MUTAMYCIN) in sodium chloride 0.9% 40 mL chemo bladder instillation Route:** intravesical **Frequency:** once **Frequency Limit:** 1 Occurrences
Product Admin Instructions:
For BLADDER IRRIGATION ONLY -- NOT for IV use!

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

○ **gemcitabine (GEMZAR) chemo bladder instillation**

☑ **gemcitabine (GEMZAR) in sodium chloride 0.9% 100 mL chemo bladder instillation** **Dose:** 2000 mg **Route:** intravesical **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op **Minimum Infusion Duration:** 1.000 Hours
Admin Instructions:
Urethral catheters are to be unclamped after 1 hour of instillation or sooner if patients experienced significant discomfort.

Cysview/Blue light Cystoscopy

☐ **Cysview/Blue light Cystoscopy**

☑ **hexaminolevulinate (CYSVIEW) intravesical solution** **Dose:** 100 **Route:** intravesical **Frequency:** once **Phase of Care:** Pre-op
Admin Instructions:
Preop nursing to instill for 1 hour prior to Procedure.

☐ **Straight cath**

☑ **Straight cath** **Frequency:** Once **Priority:** Routine **Comments:** 12-16 Fr. Catheter. Coude Catheter may be used. If difficulty placing catheter or administering medication call/page urology team.

☐ **Insert and maintain Foley**

☑ **Insert Foley catheter** **Frequency:** Once **Priority:** Routine **Comments:** 12-16 Fr. Catheter. Coude Catheter may be used. If difficulty placing catheter or administering medication call/page urology team.
Question(s):
Type:
Size:
Urinometer needed:
Indication:
Primary Ordering Comments:
Foley catheter may be removed per nursing protocol.

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

☑ **lidocaine HCL (URO-JET) 2 % jelly** **Dose:** 2 **Route:** Topical **Frequency:** once **Frequency Limit:** 1 Occurrences **Phase of Care:** Pre-op

Jelmyto

☐ **sodium bicarbonate and Jelmyto**

Jelmyto is restricted to urology, hematology, and oncology for patients with prior financial approval in the outpatient setting.

☑ **sodium bicarbonate tablet** **Dose:** 1300 mg **Route:** oral **Frequency:** once **Frequency Limit:** 1 Occurrences
Admin Instructions:
provide 30 minutes prior to instillation

☑ **mitoMYcin (JELMYTO) for pyelocalyceal instillation (RESTRICTED)** **Dose:** 15 mL **Route:** intra-pyelocalyceal **Frequency:** once **Frequency Limit:** 1 Occurrences
Question(s):
This medication is RESTRICTED to hematology, oncology, and urology specialists for new starts of therapy. All provider types can continue home therapy. Can you attest that these restrictions have been met?
This medication is restricted to use in patients with prior financial approval in the outpatient setting. Do you attest that the restrictions for this medication have been met?

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

Urology Generic Pre-Op (1795)

Version: 29 **Gen:** 11/3/2026

VTE

Low Risk Definition	Moderate Risk Definition Pharmacologic prophylaxis must be addressed. Mechanical prophylaxis is optional unless pharmacologic is contraindicated.	High Risk Definition Both pharmacologic AND mechanical prophylaxis must be addressed.
Age less than 60 years and NO other VTE risk factors	**One or more** of the following **medical conditions**:	**One or more** of the following **medical conditions**:
	CHF, MI, lung disease, pneumonia, active inflammation, dehydration, varicose veins, cancer, sepsis, obesity, previous stroke, rheumatologic disease, sickle cell disease, leg swelling, ulcers, venous stasis and nephrotic syndrome	Thrombophilia (Factor V Leiden, prothrombin variant mutations, anticardiolipin antibody syndrome; antithrombin, protein C or protein S deficiency; hyperhomocysteinemia; myeloproliferative disorders)
	Age 60 and above	Severe fracture of hip, pelvis or leg
	Central line	Acute spinal cord injury with paresis
	History of DVT or family history of VTE	Multiple major traumas
	Anticipated length of stay less than 48 hours	Abdominal or pelvic surgery for CANCER
	Less than fully and independently ambulatory	Acute ischemic stroke
	Estrogen therapy	History of PE
	Moderate or major surgery (not for cancer)	
	Major surgery within 3 months of admission	

Labs

☐ **COVID-19 Qualitative PCR**

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

Laboratory

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

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

- [ ] **Electrolyte panel** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [ ] **Creatinine level** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [ ] **BUN level** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood **Maximum Quantity:** 3
- [ ] **Hemoglobin and hematocrit** **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
- [ ] **Type and screen** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood
- [ ] **Prothrombin time with INR** **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.
- [ ] **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.
- [ ] **Urinalysis, automated with microscopy** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Urine
  Primary Ordering Comments:
  Specimen must be received in the laboratory within 2 hours of collection.
- [ ] **hCG QUALitative, urine** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Urine
  Question(s):
  Release to patient (Note: If manual release option is selected, result will auto release 5 days from finalization.):
- [ ] **Bedside glucose** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine **Specimen Type:** Blood

Cardiology

Imaging

Imaging

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

Other Studies

Other Diagnostic Studies

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

Respiratory

Rehab

Consults

For Physician Consult orders use sidebar

Consults

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

☐ **Consult Anesthesiology** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

☐ **Consult Cardiology** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Reason for Consult?
Provider Group:
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

☐ **Consult Internal Medicine** **Frequency:** Once **Phase of Care:** Pre-op **Priority:** Routine
Question(s):
Provider Group:
Reason for Consult?
Patient/Clinical information communicated?
Patient/clinical information communicated?
To Provider:
Provider Group:

☐ **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 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?

Additional Orders

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