ALASKA REGIONAL HOSPITAL

PREOPERATIVE ORDERS

NOTE: ❑ Only those orders checked (" ✓ ") will be executed. • All orders will be executed.

DRUG SENSITIVITY: *NKDA ❑

*Patient's Full Name: | *Date of Birth:

*Date of Surgery: | *Time of Surgery: | Duration of Surgery: | *Wt:_____**KG**

*❑ Admit to Inpatient Status *❑ Place patient in Outpatient Status | Code Status: ❑ Full Code ❑ DNR

*CONSENT TO READ (Procedure to be Performed):

_____

_____

*Diagnosis_____ *ICD10 Code_____ *CPT Code_____

*TYPE OF ANESTHETIC SUGGESTED (may check more than one):

- Initiate Preoperative Anesthesia Protocol

❑ General ❑ Local ❑ Regional Block ❑ Moderate Sedation ❑ MAC Other_____

Anesthesiology Consult: Call Operating Room Scheduling for Anesthesiologist Consult at ext. 2050

*PRESCREENING EXAMINATION:

❑ CBC ❑ CMP ❑ Chem7 ❑ Lytes ❑ Glucose ❑ PT/PTT

❑ UA ❑ HCG qual ❑ RPR ❑ Hep Acute ❑ HIV

❑ T&S ❑ T&C # Units:_____ ❑ COVID-19 Nasal Swab

❑ CXR ❑ EKG

❑ Other_____

❑ Autologous (Where collected?) _____ Other_____

PREOP PREP:

Prep: ❑ Clip and wash with Chlorhexidine Surgical Scrub (*Betadine if allergic*)
❑ Clip and wash with ChloraPrep Scrub (*Betadine if allergic*)

❑ Offer Fleets Enema ❑ Foley catheter to be placed in OR

❑ NPO After_____ (Stress NO food, milk, OJ, clear liquids *per anesthesia protocol*)

Should patient take current medications before surgery: ❑ No ❑ Yes _____

❑ Patient to take HALF their usual dose of Insulin morning of surgery ❑ Patient may continue current pain medications

MRSA SCREEN:

- Complete MRSA screening if patient high-risk (I.e. Any transfer from another facility/Hemodialysis admissions/NICU babies born outside of ARH/patients with open-draining wounds/patients receiving the following surgical procedures: CABG and/or Valve Replacement/Total Joint Replacement/Lumbar Laminectomies/Spinal Fusions/Anterior and Posterior Cervical Fusions)

*_____ _____ _____

PHYSICIAN SIGNATURE ***DATE*** ***TIME***

Telephone Order. Received From: _____(*LIP)	**Date_____**	**Time_____**
Telephone Order Written, Read Back & Verified by RN:_____	**Date_____**	**Time_____**

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***VTE PROPHYLAXIS:**

- ❑ Graduated Compression Stockings: ❑ Knee-high ❑ Thigh-high
- ❑ Sequential Compression Device: ❑ Calf ❑ Thigh
- ❑ Foot Pumps
- ❑ Prophylaxis not indicated; patient at low risk for VTE

***BETA BLOCKER:**

For patients on prior beta blocker therapy:

- ❑ RN administer (medication dose)_____ *with small sip of water*
- ❑ Do not administer beta blocker – patient to take own prescription day of surgery
- ❑ Hold beta blocker due to_____

ANTIBIOTIC: **Prophylactic Antibiotic to be Received within One Hour Prior to Surgical Incision*

TOTAL JOINT REPLACEMENT SURGERIES:

- ❑ Follow attached Stop Surgical Site Infection Preoperative Orders

OR

- ❑ Cefazolin 2 g *(Patients <120 kg)* OR Cefazolin 3 g *(Patients >120 kg)* IV x 1 dose
- ❑ Vancomycin 15 mg/kg rounded to nearest 250 mg IV x 1 dose (**Check Rationale for Using**)
  - ❑ MRSA colonization or infection
  - ❑ Transfer from another hospital after 3 day stay
  - ❑ Chronic wound care or Dialysis
  - ❑ High risk due to extended care setting or inpatient admission in the last year

Other:_____

Choose **ONE** of the following for patients *with* a true β-lactam (Penicillin or Cephalosporin) allergy

- ❑ Clindamycin 900 mg IV x 1 dose
- ❑ Vancomycin 15 mg/kg rounded to nearest 250 mg IV x 1 dose

HYSTERECTOMY AND COLO-RECTAL SURGERIES:

- ❑ Cefotetan 2 g IV x 1 dose

Choose **ONE** of the following for patients *with* a true β-lactam (Penicillin or Cephalosporin) allergy

- ❑ Clindamycin 900 mg IV x1 dose + Gentamicin 5 mg/kg IV x1 dose
- ❑ Metronidazole 500 mg IV x1 dose + Gentamicin 5 mg/kg IV x1 dose

OTHER SURGERIES:

- ❑ Cefazolin 2 g *(Patients <120 kg)* OR Cefazolin 3 g *(Patients >120 kg)* IV x 1 dose
- ❑ **Other Antibiotic**_____
- ❑ **NA**

❑ **All outside test results to be delivered to Admitting or faxed to 907-264-1566**

❑ H&P ❑ Old chart to OR with patient

ADDITIONAL ORDERS:

_____

_____

_____

* _____ _____ _____

Physician Signature *Date* *Time*

Telephone Order. Received From: _____	**(*LIP)**	**Date**_____	**Time**_____
Telephone Order Written, Read Back & Verified by RN:_____		**Date**_____	**Time**_____

ALASKA REGIONAL HOSPITAL
PREOPERATIVE ORDERS

POS
Form: POS.SURG.10 td 4/20

PLACE PATIENT LABEL HERE

SCANNED