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## PRE-OP ORDERS

Pre-Op Coordinator Fax: 661.200.1216

or 661.200.1486

preopdocs@henrymayo.com Patient Name: Patient Date of Birth: Planned Procedure/Surgery: Procedure/Surgery Date: Known Allergies: Procedure/Surgery Time: Optional orders (a) must be checked by physician if desired. All other orders automatically apply unless deleted with a line through and have physician's initials. ☐ Pt Status: Outpatient Surgery OR Main ☐ Pt Status: Outpatient Surgery OPSC (ACC) □ Pt Status: Inpatient □ Med/Surg □ With Telemetry – AHA Indication:\_\_ □ DOU □ ICU □ Women's Unit □ Pre-Op Diagnosis/Reason for procedure:\_ **Diagnostics** □ CBC □ BMP □ H&H □ PT/INR □ K+ □ PTT □ Glucose □ ECG □ U/A □ POC Urine Pregnancy □ CXR 1 View (Indicated for active cardiac/pulmonary symptoms) Indication:\_\_ □ Other Lab Orders: Blood Bank □ Type & Screen □ Type & Crossmatch \_\_\_\_\_ Units PRBC □ CONSENT: □ CONSENT:\_ □ VTE Prevention: SCDs (Sequential Compression Devices) ☐ Nasal Betadine 1 gm each nostril. If allergic to Iodine: Mupirocin 1 gm each nostril □ 2% Chlorhexidine Wipe in Pre Op To be determined by physician only: □ Scopolamine 1.5 mg Transdermal once — Scopolamine Patch is indicated for patients between 18 and 65 years **ERAS Pre-Op Multimodal Analgesia Medications** AND has 3 or more of the following risk factors: ☐ Acetaminophen 1000 mg PO Once Female gender - Non-smoker ☐ Gabapentin 300 mg PO Once History of post op n/v - Expected use of opioids ☐ Celecoxib 400 mg PO Once (Not History of motion sickness recommended for patients with severe renal disease; eGFR less than 30) **ERAS Pre-Op Kit Prior to Surgery** ☐ CHG and Mittens ☐ Pre-Surgery Carbohydrate Drink (not recommended for Diabetic Type I patients) Pre-Op Antibiotic □ Cefazolin 2 gram □ Cefazolin 3 gram (>120 Kg) IVPB 200 mL/hr on call to OR For Severe Penicillin Allergy or Cephalosporin Allergy ☐ Clindamycin 900 mg IVPB 50 mL/hr on call to OR ☐ Clindamycin 900 mg IVPB 50 mL/hr and Levofloxacin 500 mg IVPB 100 mL/hr on call to OR ☐ Metronidazole 500 mg IVPB 100 mL/hr and Levofloxacin 500 mg IVPB 100 mL/hr on call to OR □ Vancomycin 15 mg/kg IVPB on call to OR □ Other Medication Orders: **Informed Consent:** □ Risks □ Alternative Choices Benefits □ Potential Complications **History & Physical:** ☐ Yes ■ Who (explain) \_ Plan for Anesthesia: ☐ General □ Local □ MAC □ Regional ■ Moderate Sedation Form "Indications for Spinal Surgery": ☐ Yes □ No (explain) \_\_\_ Form "Indications for TJR Surgery": ☐ Yes □ No (explain) \_\_\_\_\_



Copy of Pre-Authorization:

**Physician Signature:** 

☐ Yes

■ No (explain) \_

Date:

Time: