

Pre-Procedure Physician Orders – Colo-Rectal ESR

Authorization is given to dispense the generic equivalent

Patient Status:

- Admit to Inpatient Status: _____ (medical reason).
- Place patient in Outpatient Status: _____ (medical reason).
- Place patient in Outpatient Status and begin observation services: _____ (medical reason).

Location: _____ Assign to Physician: _____

- I certify that the ordered level of care is based on Medical Necessity as documented within this medical record. 42 CFR Section 456.60 – Certification/Recertification.

Diagnosis: _____

Allergies: _____ **Date of Surgery:** _____

Consent for: _____

Medical Evaluation by Dr. _____

Labs/Dx tests are available at _____ office.

Pre-Admission Visit:

- CBC BMP PT PTT UA reflex EKG CXR
- Type and Screen Type and X-match for _____ Units. Autologous Units _____.
- Other: _____
- Neomycin 1 gram orally and Flagyl 1 gram orally day prior to procedure
- Active Surveillance screen for MRSA/MSSA colonization for dialysis patients, nursing home or other healthcare facility patients, incarcerated patients, or history of open wound patients.
- The patient will be given instructions for **a.** "Pre-surgical Home Scrub" with chlorhexidine; **b.** Pre-surgical carbohydrate-rich beverage intake; **c.** If Surveillance screening is positive, Mupirocin nasal ointment.
- No solid food after midnight. Clear liquid diet up to 2 hours prior to surgery.
- If patient is on Beta Blockers, instruct patient to take the morning of surgery with a sip of water.

Day of Procedure:

IF the patient has not taken their beta blocker within the last 24 hours, then administer:

(Drug/Dose/Route of Administration) _____

IV: LR at 100mL/hr. Normal Saline at 100mL/hr. IVF _____ at _____ ml/hr.

VTE Prophylaxis:

- Intermittent pneumatic compression devices (SCD'S)
- Graduated compression stockings
- Heparin 5,000 units subcutaneous x 1 pre-operative
- Heparin contraindicated due to _____

***Physician Signature:** _____ ***Date:** _____ ***Time:** _____

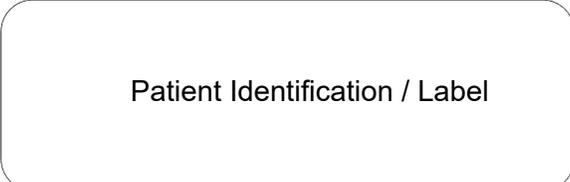
***Physician Name (BLOCK LETTERS):** _____

***Patient Name:** _____ ***DOB:** _____

* = Required Information



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Day of Procedure continued:

If MRSA screen is positive:

- Place patient on contact precautions.
- Mupirocin nasal ointment apply in each nare twice a day for 5 days.
- Vancomycin 15 mg/kg (rounded to the nearest 250 mg) IVPB within 120 minutes of incision.

Antibiotic Prophylaxis

- Cefoxitin (Mefoxin) 2 gm IVPB within 60 minutes of incision.
- Flagyl 500 mg IVPB within 60 minutes of incision, **PLUS**
Cefazolin (Ancef/Kefzol) Weight less than 120 kg: 2 gram IVPB within 60 minutes of incision.
Weight of 120 kg or greater: 3 grams IVPB within 60 minutes of incision.

If Beta Lactam Allergy

- Flagyl 500 mg IVPB within 60 minutes of incision, **PLUS** one below:
 - Gentamicin 5 mg/kg IVPB within 60 minutes of incision.
 - Ciprofloxacin 400 mg IVPB within 60 minutes of incision.
 - Levofloxacin 500 mg IVPB within 60 minutes of incision.

Pre-Op

- Acetaminophen 975 mg po x 1 in pre-op holding
- Gabapentin 300 mg po x 1 in pre-op holding
- Celebrex 200 mg po x 1 in pre-op holding
- Decadron 4 mg IV x 1 in pre-op holding

Alvimopan (ENTEREG)

For patient scheduled for a partial large or small bowel resection surgery with primary anastomosis.

By CHECKING all information the items listed, I confirm that I have verified the following conditions:

- Patient is scheduled for a partial large or small bowel resection surgery with primary anastomosis
- Patient has not taken therapeutic doses of opioids for more than 7 consecutive days immediately prior to alvimopan (Entereg) therapy
- Patient does not have severe hepatic impairment
- Patient does not have end-stage renal disease
- No Complete Bowel Obstruction
- Patient is 18 years and older Pre-Op
- Alvimopan (Entereg) 12 mg capsule PO x 1 prior to transferring patient to pre-op holding area. May be given 30 minutes to 5 hours prior to surgery with 1 ounce of water only

Other: _____

*Physician Signature: _____ *Date: _____ *Time: _____

*Physician Name (BLOCK LETTERS): _____

*Patient Name: _____ *DOB: _____

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Patient Identification / Label