

Do Not Use Abbreviations: U (for Unit), IU for International unit), Q.D., Q.O.D., Trailing Zero (X.0 mg) MS, MSO4 MgSO4

Podiatry/Orthopedic Pre-Operative Orders

- Status:** Admit to Inpatient Status (I certify that inpatient services are needed)
 Place Patient in Outpatient Status
 Place Patient in Outpatient Status and begin Observation Services

Admit to the service of:

PATIENT NAME (LAST):		FIRST NAME	DATE OF BIRTH:
DIAGNOSIS:			ANESTHESIA TYPE:
PROCEDURE CONSENT TO STATE:			
DATE OF SURGERY/PROCEDURE	PHYSICIAN:	PRIMARY PHYSICIAN:	
CPT CODE(S)			

ALLERGIE(S)

Type of Reaction(s):

Patient Weight: _____ kg

PRE-OP MEDICATIONS:

IV FLUIDS:

- Peripheral IV access
- Lactated Ringers @ 30 mL/hr on arrival to Preop
- 0.9% Sodium Chloride @ 30 mL/hr on arrival to Preop
- _____

PRE-OP ANTIBIOTICS: Infuse within 60 minutes prior to surgery

- Patient weight < 60 kg: cefazolin 1 gm IV
- Patient weight 60-120 kg: cefazolin 2 gm IV
- Patient weight > 120 kg: cefazolin 3 gm IV

If beta-lactam allergy or has a history or risk for MRSA, give vancomycin; For hip or knee replacement, if positive or unknown MRSA nasal surveillance swab, give cefazolin with vancomycin:

Vancomycin Dose: Infuse within 120 minutes prior to surgery

- Patient weight < 50 kg: Vancomycin 750 mg IV over 60 minutes
- Patient weight 50 - 100 kg: Vancomycin 1 gm IV over 60 minutes
- Patient weight > 100 kg: Vancomycin 1.5 gm IV over 90 minutes

If beta-lactam and vancomycin intolerant, give clindamycin:

- Clindamycin 900 mg IV over 30 minutes, start 60 minutes prior to surgery

Enhanced Surgical Recovery

Diet:

- No solid food after midnight the night before the procedure unless otherwise instructed by anesthesia.
- May have clear liquids (NO RED COLOR OR DYE) up to arrival time at JFKN or until 2 hours before scheduled surgery.
- If instructed to do bowel prep prior to surgery, no solid food starting at midnight 2 nights prior to surgery.
- INSTRUCT PATIENT TO DRINK pre-surgery drink:**
 - Drink 2 bottles evening prior to surgery and drink one bottle at least 2 hours prior to scheduled surgery time.
 - If patient is Diabetic**, substitute Gatorade Zero for pre-surgery drink and instruct to drink one 20 oz. bottle the evening prior to procedure and one-half bottle of Gatorade zero 2 hours prior to scheduled procedure.
- Instruct patient to shower/bathe with 2% chlorhexidine gluconate (CHG) shower soap the night before surgery and repeat the morning of surgery.
- Upon arrival to preop have patient wipe body down with 2% chlorhexidine gluconate (CHG) wipes.

Physician Signature: _____ Print Name: _____ Date/Time: ____/____/____ at: _____

PODIATRY-ORTHO
PRE OPERATIVE ORDERS



POS HCAFL-H-JFKN-10004
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Patient Identification/Label

Podiatry/Orthopedic Pre-Operative Orders

<p>MEDICATIONS: A. To be given in preop day of surgery, or B. Patient given script to take medication prior to arrival</p> <p><input type="checkbox"/> Acetaminophen 975 mg PO x 1</p> <p><input type="checkbox"/> Acetaminophen 650 mg liquid PO x 1</p> <p><input type="checkbox"/> Acetaminophen 1gm IV x 1</p> <p><input type="checkbox"/> Celecoxib 200 mg PO x 1</p> <p><input type="checkbox"/> Gabapentin (Neurontin) 600 mg PO x 1 <i>Reminder: If age > 75, patient on dialysis, or <50kg weight, give:</i></p> <p><input type="checkbox"/> Gabapentin (Neurontin) 300 mg PO x 1</p> <p><input type="checkbox"/> Oxycodone SUSTAINED release (Oxycontin) 10 mg PO x1</p> <p><input type="checkbox"/> Oxycodone IMMEDIATE release (OxyIR) 10 mg PO x 1</p> <p><input type="checkbox"/> Metoclopramide 10 mg IV x 1</p> <p><input type="checkbox"/> Tranexamic acid 1gm IV x 1</p> <p><input type="checkbox"/> Other medication order: _____</p> <p><input type="checkbox"/> Tramadol 50mg PO x 1</p> <p><input type="checkbox"/> Dexamethasone 8mg PO x 1 (DO NOT ORDER IF DIABETIC)</p>	<p><i>Reminder: Contraindicated in patients with glaucoma or elevated intraocular pressure</i></p> <p><i>Reminder: Do not give if age >65</i></p> <p><input type="checkbox"/> SCOPOLAMINE HYDROBROMIDE 1 PATCH TRANSDERM PREOP. APPLY UPON ARRIVAL BEHIND EAR and GIVE PATIENT SCOPOLAMINE INSTRUCTION SHEET</p> <p><input type="checkbox"/> VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS (must select one)</p> <p><input type="checkbox"/> enoxaparin (Lovenox) 40 mg subcutaneous x1 preop</p> <p><input type="checkbox"/> heparin 5,000 units subcutaneous x1 preop</p> <p><input checked="" type="checkbox"/> Calf-high Sequential Compression Device to be placed in preop</p>
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EKG Done at: JFK North Campus PCP

Must Be Legible Copy

<p>Labs Done at: <input type="checkbox"/> JFKN <input type="checkbox"/> Outside Testing</p> <p>Please use Anesthesia Guidelines to determine testing.</p> <p><input type="checkbox"/> A1C</p> <p><input type="checkbox"/> CBC <input type="checkbox"/> CBC With Differential</p> <p><input type="checkbox"/> BMP (Basic Metabolic Profile)</p> <p><input type="checkbox"/> CMP (Complete Metabolic Profile)</p> <p><input type="checkbox"/> Liver Profile <input type="checkbox"/> PT, PTT & INR</p> <p><input type="checkbox"/> Sickle Cell <input type="checkbox"/> Urine BHCG (qual)</p> <p><input type="checkbox"/> Urinalysis <input type="checkbox"/> CEA</p> <p><input type="checkbox"/> Urine Culture & Sensitivity</p> <p><input type="checkbox"/> Type & Screen</p> <p><input type="checkbox"/> Type & Cross X _____ units</p> <p><input type="checkbox"/> MRSA/MSSA Screening (required for all total knees and total hips)</p> <p>Other Labs: _____</p> <p><input type="checkbox"/> Incentive Spirometer</p> <p><input checked="" type="checkbox"/> Instruct 2% chlorahexadine bathing Case Management to Arrange:</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> Rolling Walker</p>	<p>Medical Pre Op Evaluation: Phone: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Dr.: _____</p> <p>Cardiac Pre Op Evaluation: Phone: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Dr.: _____</p> <p>Other Pre Op Evaluation (Type): Phone: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Dr.: _____</p> <p>Other Pre Op Evaluation (Type): Phone: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Dr.: _____</p> <p>Patient From Nursing Home/Extended Care Facility? Phone: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes Name: _____</p> <p><input type="checkbox"/> NPO AFTER MIDNIGHT, DATE: _____</p> <p><input type="checkbox"/> Chest X-Ray <input type="checkbox"/> JFKN <input type="checkbox"/> Outside testing</p> <p>MRI: _____ CT: _____</p> <p>Obtain Test Results: <input type="checkbox"/> OTHER _____ DONE AT : _____ ADDITIONAL ORDERS: _____</p> <p><input type="checkbox"/> Popliteal Block <input type="checkbox"/> Single <input type="checkbox"/> Catheter <input type="checkbox"/> On Q Pump</p>
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PERSON COMPLETING FORM:	NAME (PLEASE PRINT): _____
	DATE: _____ TIME: _____
PHYSICIAN'S SIGNATURE:	PHYSICIAN'S NAME (PLEASE PRINT): _____
	DATE: _____ TIME: _____

Patient Name and Date of Birth (for offices) _____

PODIATRY-ORTHO
 PRE OPERATIVE ORDERS



Patient Identification/Label