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

Cardiac Surgery 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 CODES:

ALLERGIE(S) _____
Type of Reaction(s):_____
Patient Weight: _____ kg

IV fluids:
☐ Lactated Ringers @ 30 mL/hr on arrival to Preop
☒ 0.9% Sodium Chloride @ 30 mL/hr on arrival to Preop
☐ _____

Preop antibiotics:
For NEGATIVE MRSA/MSSA or POSITIVE MSSA surveillance swab results:
☐ Cefazolin 1 gm IV for patient weight < 60 kg, infuse within 60 minutes prior to surgery
☐ Cefazolin 2 gm IV for patient weight 60-120 kg, infuse within 60 minutes prior to surgery
☐ Cefazolin 3 gm IV for patient weight > 120 kg, infuse within 60 minutes prior to surgery
If beta-lactam allergy or penicillin allergy give:
☐ Vancomycin 15mg/kg IV over 60 minutes, infuse within 60 minutes prior to incision **PLUS**
☐ Gentamicin 5mg/kg IV over 60 minutes, infuse within 60 minutes prior to incision
For POSITIVE OR UNKNOWN MRSA surveillance swab results:
☐ Vancomycin 15mg/kg IV over 60 minutes, infuse within 60 minutes prior to incision **PLUS**
(Choose only one of the following):
☐ Cefazolin 1 gm IV for patient weight < 60 kg, infuse within 60 minutes prior to surgery
☐ Cefazolin 2 gm IV for patient weight 60-120 kg, infuse within begin 60 minutes prior to surgery
☐ Cefazolin 3 gm IV for patient weight > 120 kg:, infuse within 60 minutes prior to surgery
If beta-lactam allergy or penicillin allergy give:
☐ Gentamicin 5mg/kg IV over 60 minutes, infuse within 60 minutes prior to incision
If beta-lactam and vancomycin intolerant, give clindamycin instead of cefazolin or vancomycin:

**** If allergic to Vancomycin call Infectious disease physician for alternative**

INSTRUCT PATIENT TO:

_____

_____

_____

_____

Medications to take day of procedure: _____

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

Patient Identification/Label

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 JFK 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.

Do Not Administer Pre-Surgery drink if patient is a Type 1 Diabetic on Dialysis, or is Insulin Dependent.

<u>If patient is Type 1 Diabetic or insulin dependent</u> substitute Gatorade Zero for pre-surgery drink and instruct to drink one 20oz. 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.

<u>Medications:</u>

A. To be given in pre-op day of procedure

☐ **Patient given prescription to take the medication prior to arrival for surgery**

☐ Acetaminophen 975 mg PO x 1 dose if patient <65 kg give 650 mg Acetaminophen PO x 1

☒ Acetaminophen 650mg PO x1 in Pre-Op

☐ Acetaminophen 1gm IV x 1

☐ Gabapentin (Neurontin) 600 mg PO x 1 preop

Reminder: If age > 75, patient on dialysis, or <50kg weight, give:

☐ Gabapentin (Neurontin) 300 mg PO x 1 preop

☐ Metoclopramide 10 mg IV x 1 dose

☐ Other medication order: _____

☐ Pregabalin 75 mg Pox1

☐ Tramadol 50mg PO x 1

☒ Dexamethasone 4mg IV x1 ☐ Dexamethasone 8mg PO x 1 (DO NOT ORDER IF DIABETIC)

☒ Lidocaine Patch 4%. Apply post-operatively in PACU proximal to surgical site.

<u>Venous Thromboembolism (VTE) Prophylaxis (MUST SELECT ONE)</u>

☐ Enoxaparin (Lovenox) 40 mg Subcutaneous x 1 dose in preop

☐ Heparin 5,000 units subcutaneous x 1 dose in preop

☒ Calf-high Sequential Compression Device to be placed in preop

Physician Signature: _____ Date/Time: _____ / _____ / _____ at: _____

Patient Identification/Label

Cardiac Surgery Pre-Operative Orders (con't)

PATIENT NAME (LAST): _____ FIRST NAME _____ DATE OF BIRTH: _____

Labs Done at: ☐ JFK ☐ Outside Testing

Please use Anesthesia Guidelines to determine testing.

- ☐ Hemoglobin A1C
- ☐ CBC ☐ CBC With Differential
- ☐ Platelet Function Assay (cardiac) ☐ PT, PTT & INR
- ☐ BMP (Basic Metabolic Panel) ☐ CMP (Complete Metabolic Panel)
- ☐ Liver Profile ☐ HIV Screening
- ☐ Direct Bilirubin ☐ Pre-albumin
- ☐ Sickle Cell
- ☐ Urinalysis ☐ P2Y12 ☐ Urine Reflex
- ☐ Urinalysis with Reflex Culture ☐ BNP
- ☐ Type & Screen ☐ PRBC #_____units
- ☐ Urine BHCG (qual) ☐ Serum BHCG (qual)
- ☒ MRSA/MSSA Screening (swab both anterior nares with single swab)
- ☐ Arterial Blood Gas on Room Air

Other Labs: _____

- ☐ Complete Pulmonary Function Test
- ☒ Record actual height and weight on chart
- ☒ Record BP in Right and Left Arms
- ☐ Anti Embolic Hose
- ☒ Sequential Compression Device(s)
- ☒ Incentive Spirometer
- ☒ Chlorhexidine Gluconate 2% bathe every 12 hours
- ☐ Give prescription for Mupirocin Ointment 2% to be applied nasally every 12 hours starting _____

Obtain Pre Op Consult Reports: Phone: _____
☐ No ☐ Yes Dr.: _____

Cardiac: Phone: _____
☐ No ☐ Yes Dr.: _____

Other (Type): _____ Phone: _____
☐ No ☐ Yes Dr.: _____

Other (Type): _____ Phone: _____
☐ No ☐ Yes Dr.: _____

Patient From Nursing Home/ Extended Care Facility? Phone: _____
☐ No ☐ Yes Name: _____

☐ NPO AFTER MIDNIGHT, DATE: _____

RADIOLOGY TESTING:

☐ **Chest X-Ray** ☐ JFK ☐ Outside testing
Must Be Legible Copy

☐ **EKG** Done at: ☐ JFK ☐ PCP

- ☐ Bilateral upper extremity arterial ultrasound to measure diameter of radial and ulnar arteries
- ☐ Bilateral carotid ultrasound
- ☐ Bilateral venous image ultrasound to measure diameter of greater and lesser saphenous veins
- ☐ Bilateral venous imaging of lower extremities to rule out deep vein thrombosis (DVT)

Obtain Test Results:

☐ Cardiac Cath ☐ Echocardiogram
☐ Stress Test ☐ TAVR CT

OTHER: _____

DONE AT : _____

OTHER: _____

PERSON COMPLETING FORM:	NAME (PLEASE PRINT): DATE: TIME:
PHYSICIAN'S SIGNATURE:	PHYSICIAN'S NAME (PLEASE PRINT): DATE: TIME:

Patient Identification/Label