

# ENT/HEAD & NECK PRE-OPERATIVE PHYSICIAN ORDERS

Attn: Pre-Assessment Fax (805) 418-1386 / Phone (805) 418-1354 or (805) 418-1355

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Physician: \_\_\_\_\_ Surgery Date: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM

Diagnosis: \_\_\_\_\_ Patient Type:  Inpatient  Outpatient

Allergies: \_\_\_\_\_

History and Physical to be performed by: \_\_\_\_\_ M.D.

Consent to Read: \_\_\_\_\_

NPO after Midnight

Pre-Operative Prep: \_\_\_\_\_

CXR  EKG (> 50 years old per Anesthesia protocol)

Pre-Op Antibiotic:

- ANCEF 1 gram IV within 60 minutes prior to incision
- CLINDAMYCIN 600 mg IV within 60 minutes prior to incision

VTE Prophylaxis based on:  Low Risk  Moderate Risk  High Risk  None  Contraindicated: \_\_\_\_\_

Compression Device:  Sequential  Plexi Pulse  Bilateral  Right  Left Ted Hose:  Knee High  Thigh High

Other Pre-Op Orders: \_\_\_\_\_

- No Lab work required  Lab work completed by internal medicine MD (Please fax to Pre-Assessment RN)  Labs will be done at alternate Lab (name of Lab.)

### LABORATORY TESTS

CHEMISTRY
<input type="checkbox"/> Electrolytes: Na,K,Cl,C02 <input type="checkbox"/> Basic Metabolic Na,K,Cl,C02,Glu,BUN,Creat,Ca <input type="checkbox"/> Comprehensive Metabolic: Na,K,Cl,C02, Glu, BUN, Creat,TP,ALB,CA, TBil,Alk Phos,ALT,AST
URINALYSIS
<input type="checkbox"/> UA W/REFLEX MICROSCOPE

SEROLOGY
<input type="checkbox"/> Pregnancy Test, Serum <input type="checkbox"/> Pregnancy Test, Urine
HEMATOLOGY
<input type="checkbox"/> CBC, Auto Diff <input type="checkbox"/> HGB & HCT <input type="checkbox"/> Hemogram <input type="checkbox"/> Westergren Sed Rate <input type="checkbox"/> Protine <input type="checkbox"/> PTT
<input type="checkbox"/> MRSA Nasal Swab

BLOOD BANK
<input type="checkbox"/> Blood Type <input type="checkbox"/> Type & Screen <input type="checkbox"/> Type & Cross # _____ Autologous # _____ Designated Donor # _____ Random
FOR LAB USE ONLY
<ul style="list-style-type: none"> <li>• Fasting <input type="checkbox"/> Y <input type="checkbox"/> N</li> <li>• Blood Thinners <input type="checkbox"/> Y <input type="checkbox"/> N</li> <li>• Previous Transfusion <input type="checkbox"/> Y <input type="checkbox"/> N</li> <li>• Pregnant &lt; 3 months <input type="checkbox"/> Y <input type="checkbox"/> N</li> </ul>

OTHER LAB ORDERS: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

RN Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Please fax this form, H&P test results, and patient medication list, prior to surgery, to the Pre-Op department at Fax No. (805) 418-1386



Patient Label: \_\_\_\_\_