

GENERAL SURGERY 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:

Laparoscopic Appendectomy:

- ANCEF 1 gram IV and METRONIDAZOLE 500 mg IV within 60 minutes prior to incision
- METRONIDAZOLE 500 mg IV and GENTAMICIN 80 mg IV within 60 minutes prior to incision. If documented β lactam allergy **or**
- CLINDAMYCIN 600 mg IV and GENTAMICIN 80 mg IV within 60 minutes prior to incision. If documented β lactam allergy

Laparoscopic Cholecystectomy: (ONLY if Age \geq 70)

- ANCEF 1 gram IV within 60 minutes prior to incision
- CLINDAMYCIN 600 mg IV within 60 minutes prior to incision If documented β lactam allergy **or**
- CLINDAMYCIN 600 mg IV and GENTAMICIN 80 mg IV within 60 minutes prior to incision. If documented β lactam allergy

Colon:

- ANCEF 1 gram IV within 60 minutes prior to incision
- METRONIDAZOLE 500 mg IV and GENTAMICIN 80 mg IV within 60 minutes prior to incision. If documented β lactam allergy **or**
- CLINDAMYCIN 600 mg IV and GENTAMICIN 80 mg IV within 60 minutes prior to incision. If documented β lactam allergy

Other Procedure:

- ANCEF 1 gram 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 Labs will be done at alternate Lab
(Please fax to Pre-Assessment RN) (name of Lab.)

LABORATORY TESTS

CHEMISTRY

Electrolytes:
Na,K,Cl,C02

Basic Metabolic
Na,K,Cl,C02,Glu,BUN,Creat,Ca

Comprehensive Metabolic:
Na,K,Cl,C02, Glu, BUN, Creat,TP,ALB,CA,
TBil,Alk Phos,ALT,AST

URINALYSIS

UA W/REFLEX MICROSCOPE

SEROLOGY

Pregnancy Test, Serum

Pregnancy Test, Urine

HEMATOLOGY

CBC, Auto Diff

HGB & HCT

Hemogram

Westergren Sed Rate

Prottime

PTT

MRSA Nasal Swab

BLOOD BANK

Blood Type

Type & Screen

Type & Cross

_____ Autologous

_____ Designated Donor

_____ Random

FOR LAB USE ONLY

• Fasting Y N

• Previous Transfusion Y N

• Pregnant < 3 months Y N

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



Thousand Oaks Surgical Hospital
 401 E. Rolling Oaks Drive • Thousand Oaks, CA 91361 • (805) 777-7750

Patient Label: _____

**PRE-OPERATIVE PHYSICIAN ORDERS
 GENERAL SURGERY FORM
 MR133 Revised 01/09 Reviewed 3/09**