

# ORTHOPEDIC/PODIATRY 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 If documented  $\beta$  lactam allergy
- VANCOMYCIN 1 gram IV within 60 minutes prior to incision **Documented justification for use required**  
Reserved for the treatment of serious infection with  $\beta$  lactam resistant organisms or for treatment of infection in patients with life threatening allergy to  $\beta$  lactam antimicrobials

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

Instruct importance and use of Incentive Spirometer

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

OTHER LAB ORDERS:

### SEROLOGY

- Pregnancy Test, Serum
- Pregnancy Test, Urine

### HEMATOLOGY

- CBC, Auto Diff
- HGB & HCT
- Hemogram
- Westergren Sed Rate
- Protime
- PTT

### MICROBIOLOGY

- MRSA Nasal Swab

### BLOOD BANK

- Blood Type
- Type & Screen
- Type & Cross
- # \_\_\_\_\_ Autologous
- # \_\_\_\_\_ Designated Donor
- # \_\_\_\_\_ Random

### FOR LAB USE ONLY

- Fasting  Y  N
- Blood Thinners  Y  N
- Previous Transfusion  Y  N
- Pregnant < 3 months  Y  N

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**

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**PRE-OPERATIVE PHYSICIAN ORDERS ORTHOPEDIC/PODIATRY**  
MR130 Revised 01/09 Reviewed 3/09

Patient Label: