

UROLOGY/GENITOURINARY 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:

Transrectal Prostate Biopsy:

- CIPRO 500 mg PO within 60 minutes prior to incision
- GENTAMYCIN 80 mg IV **And** METRONIDAZOLE 500 mg IV within 60 minutes prior to incision **or**
- GENTAMYCIN 80 mg IV **And** CLINDAMYCIN 600 mg IV within 60 minutes prior to incision

Penile Prosthesis:

- GENTAMYCIN 80 mg IV **And** ANCEF 1 gram IV within 60 minutes prior to incision
- GENTAMYCIN 80 mg IV **And** VANCOMYCIN 1 gram IV within 60 minutes prior to incision. If documented β lactam allergy or treatment of serious infection with β lactam resistant organisms. **Documented justification for Vancomycin use required.**

Epididymis or Epididymis Lesion Removal:

- 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**
- VANCOMYCIN 1 gram IV within 60 minutes prior to incision. If documented β lactam allergy or treatment of serious infection with β lactam resistant organisms. **Documented justification for use required.**

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 Ted Hose: Knee High Thigh High

Other 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
<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"> • Fasting <input type="checkbox"/> Y <input type="checkbox"/> N • Previous Transfusion <input type="checkbox"/> Y <input type="checkbox"/> N • Pregnant < 3 months <input type="checkbox"/> Y <input type="checkbox"/> 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

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UROLOGY / GENITOURINARY
MR135 Reviewed/Revised 12/2010

Patient Label: