PROVIDER ORDERS

PED GENERAL SURGERY PRE-OP (3040100527)

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Location

❑ Boise Surgery **Fax: 381-3060**	❑ Boise COU **Fax: 381-3567**	❑ Surgery Center Boise **Fax: 381-3209**	❑ Surgery Center Meridian **Fax: 706-8102**
❑ Boise Endo **Fax: 381-2135**	❑ Meridian Endo **Fax: 706-5015**	❑ Meridian Surgery **Fax: 706-2178**	❑ Wood River OR/Endo **Fax: 727-8634**
❑ OSC – River Street **Fax: 336-1954**	❑ OSC – Robbins **Fax: 489-4348**	❑ Magic Valley **Fax: 814-2921**	❑ Elmore **Fax: 580-9808**
❑ Jerome **Fax: 324-7301**	❑ McCall **Fax: 634-3818**	❑ Nampa **Fax: 205-7485**	

Patient Name (First, middle initial and last): _____

Date of Birth: _____ **Phone Number:** _____ **Case Number:** _____ **Date of Surgery:** _____

Provider Name: _____ **Allergies:** _____

Weight: _____kg **Height:** _____cm **Diagnosis:** _____ ❑ Interpretation Services; Language:_____

Pre Admission Testing ❑ N/A

❑ CBC	❑ Comprehensive Metabolic Panel	❑ MRSA and SA Screen by PCR
❑ APTT	❑ Glycohemoglobin A1C	❑ ECG 12 lead
❑ Protime-INR	❑ Hepatic Function Panel	❑ XR chest 2 view
❑ Basic Metabolic Panel	❑ Urinalysis w/C&S if Indicated	❑ Other: _____

General (Pre-Op)

❑ Admit to Inpatient ❑ Hospital Outpatient Surgery (discharge home from PACU) ❑ Hospital Outpatient Surgery (with bed)

Diet (Pre-Op)

☑ Pediatric NPO Diet ❑ Other: _____

OR Code Status (Pre-Op)

☑ Default Full Code (Not Discussed) ❑ Modified code

❑ Full code ❑ DNR/DNI

Code Status – After choosing the appropriate code status please indicate whether this code status will be respected or suspended in the OR

☑ Respect Current Code Status ❑ Suspend Code Status (Full Code in OR)

Nursing (Pre-Op)

❑ Sequential compression device ❑ Calf ❑ Insert Indwelling Urinary Catheter; Reason: Pre-Surgery/Pre-Procedure

☑ Verify informed Consent (exact wording for surgery consent): _____

_____

_____

Labs (Pre-Op / Day of Surgery) ❑ N/A

❑ CBC	❑ Basic Metabolic Panel
❑ Comprehensive Metabolic Panel	❑ Glycohemoglobin A1C
❑ Urinalysis w/C&S if Indicated	❑ Urine Culture
❑ Urine HCG Screen	❑ MRSA and SA Screen by PCR nasal only
❑ POCT blood glucose if diabetic	☑ POCT urine pregnancy per policy
❑ Type and Screen	❑ Other: _____

Blood Bank Tests and Products (Pre-Op) ❑ N/A

If preparing blood for a planned surgery, a Type and Screen needs to be resulted within 72 hours of product administration.

❑ Type and Screen ❑ Prepare RBC (greater than or equal to 40 kg ❑ 1 unit ❑ 2 units Indications: Surgical Blood Product

❑ mL Blood Administration –Red Blood Cells – Ped less than 40 kg - Indicate volume desired in primary aliquot. All blood products are leukodepleted.
Suggested Volume 15 mL/kg Volume _____mL (indicate volume desired in PRIMARY aliquot up to 55mL)
If volume greater than 55 mL is needed please indicate additional aliquots below.
Donor source options: ❑ Blood Bank ❑ Autologous Request for special products: ❑ CMV Negative ❑ Irradiated

❑ mL Blood Administration –Red Blood Cells – Ped less than 40 kg - Indicate volume desired in primary aliquot. All blood products are leukodepleted.
Suggested Volume 15 mL/kg Volume _____mL (indicate volume desired in SECONDARY aliquot up to 55mL)
If volume greater than 55 mL is needed please indicate additional aliquots below.
Donor source options: ❑ Blood Bank ❑ Autologous Request for special products: ❑ CMV Negative ❑ Irradiated

NOTE: If more than two aliquots are needed, indicate number of additional aliquots and volume in each _____

Imaging (Pre-Op / Day of Surgery) ❑ N/A

❑ XR chest 2 view ❑ Other: _____

Procedures and Other Tests (Pre-Op) ❑ N/A

❑ ECG 12 lead ❑ within 6 months ❑ Echo Pediatric Complete

PROVIDER INITIALS:

PATIENT LABEL

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Patient Name (First, middle initial and last): _____

IV

☑ Initiate IV protocol – Pediatric ❑ lactated ringers infusion _____ ml/hr ❑ Other: _____

❑ dextrose 5 % and sodium chloride 0.45 % infusion ____ ml/hr ❑ dextrose 5 % and sodium chloride 0.9 % infusion _____ ml/hr

Antibiotics (Pre-Op) ❑ N/A

General (Pre-Op)

❑ ampicillin (OMNIPEN) IV (NEO/PED) 50 mg/kg x 1 dose
❑ ampicillin-sulbactam (UNASYN) dose band syringe (PED) 75 mg/kg of ampicillin x 1 dose
❑ ceFAZolin (ANCEF) 100 mg/mL IV syringe (NEO/PED) 25 mg/kg x 1 dose
❑ ceFAZolin (ANCEF) dose band syringe (PED), 25 mg/kg x 1, IV
❑ cefoTETAN (CEFOTAN) 40 mg/mL IV syringe (NEO/PED) 40 mg/kg x 1 dose
❑ clindamycin (CLEOCIN) IV syringe (NEO/PED) 10 mg/kg x 1 dose
❑ gentamicin 2.5 mg/kg IV syringe (NEO/PED) x 1 dose
❑ metronidazole (FLAGYL) IV syringe (NEO/PED) loading dose 15 mg/kg x 1 dose
❑ metronidazole (FLAGYL) IV syringe (NEO/PED) maintenance dose 7.5 mg/kg x 1 dose
❑ piperacillin-tazobactam (ZOSYN) 100 mg/mL IV syringe (NEO/PED) 80 mg/kg of piperacillin x 1 dose for Patients 2 - 9 months of age
❑ piperacillin-tazobactam (ZOSYN) 100 mg/mL IV syringe (NEO/PED) 100 mg/kg of piperacillin x 1 dose for Infants greater than 9 months and Children and Adolescents less than or equal to 40 kg
❑ piperacillin-tazobactam (ZOSYN) 100 mg/mL IV syringe (NEO/PED) 3.375 g IV of piperacillin x 1 dose for Adolescents greater than 40 kg
❑ Pharmacy to dose aminoglycoside: _____
❑ Other: _____

Neurosurgery (Pre-Op) ❑ N/A

❑ ceFAZolin (ANCEF) 100 mg/mL IV syringe (NEO/PED) 30 mg/kg x 1 dose
❑ ceFAZolin (ANCEF) dose band, 30 mg/kg x 1, IV
❑ cefUROXime (ZINACEF) 90 mg/mL IV syringe (NEO/PED) 50 mg/kg x 1 dose, administer over 15 minutes
❑ vancomycin (VANCOCIN) 10 mg/kg IV syringe (NEO/PED) x 1 dose
❑ IP consult to Pharmacy Reason for consult: Dose vancomycin Comments: Pharmacy to adjust for renal function
❑ Other: _____

ENT (Pre-Op) ❑ N/A

❑ amoxicillin (AMOXIL) 400 mg/5 mL suspension 50 mg/kg x 1 dose
❑ ampicillin-sulbactam (UNASYN) 45 mg/mL IV syringe (NEO/PED) 50 mg/kg of ampicillin x 1 dose
❑ ampicillin-sulbactam (UNASYN) dose band syringe (PED) 75 mg/kg x 1 IV
❑ azithromycin (ZITHROMAX) 200 mg/5 mL oral suspension 10 mg/kg x 1 dose
❑ ciprofloxacin-dexamethasone (CIPRODEX) otic suspension 3 drops x 1 Dose, re-label for home use ❑ Both Ears ❑ Left Ear ❑ Right Ear
❑ mupirocin (BACTROBAN) 2 % ointment Once, Topical, For 1 Dose. Apply ointment to each nostril 3 times daily. Re-label for home use
❑ Other: _____

Anesthesia ❑ N/A

❑ Bier Block	❑ SAB	❑ Epidural	❑ Regional Block
❑ General	❑ TIVA	❑ Local with Conscious Sedation (No Anesthesia resource involved)	
❑ Local with NO Sedation (No Anesthesia Resource involved)		❑ MAC	❑ TBD by Anesthesia

Type of Optional Post-Op Analgesia ❑ N/A

❑ Adductor canal	❑ Popliteal	❑ Epidural
❑ Caudal	❑ Sciatic	❑ Femoral
❑ Fascia iliaca	❑ Transverse Abdominis Plane	❑ Non specified Brachial plexus block
❑ Interscalene	❑ Bier block	❑ Saphenous
❑ Spinal with Morphine	❑ Anesthesia providers choice	❑ Other – Comment Required

Additional Orders (any medication orders must include medication, dose, route and phase of care) ❑ N/A

_____

_____

PROVIDER SIGNATURE: **DATE:** **TIME:**

PATIENT LABEL