

SUMMIT MEDICAL CENTER PREADMISSION/DAY OF SURGERY ORDERS

| | | |
|---------|--------|-------------------|
| Pt Name | Pt DOB | Date/Time Surgery |
|---------|--------|-------------------|

Signature of Surgeon: _____ Date/Time _____

| PREADMISSION TESTING ORDERS | DAY OF SURGERY ORDERS |
|--|--|
| <input type="checkbox"/> PAT IN PERSON <input type="checkbox"/> PAT BY PHONE | |
| MEDICAL HISTORY <ul style="list-style-type: none"> <input type="checkbox"/> CAD <input type="checkbox"/> PROBLEM WITH ANESTHESIA <input type="checkbox"/> OSA <input type="checkbox"/> DIABETES – POORLY CONTROLLED <input type="checkbox"/> HTN, > 2 MEDS <input type="checkbox"/> COPD – ON O² <input type="checkbox"/> ESRD <input type="checkbox"/> MORBID OBESITY <input type="checkbox"/> Hx OF MRSA <input type="checkbox"/> REQUESTS TO MEET IN PERSON WITH ANESTHESIOLOGIST | <ul style="list-style-type: none"> <input type="checkbox"/> OUTPATIENT STATUS (SOP) <input type="checkbox"/> INPATIENT STATUS <ul style="list-style-type: none"> <input type="checkbox"/> ANTICIPATED LOS = LESS THAN TWO MIDNIGHTS <input type="checkbox"/> ANTICIPATED LOS = MORE THAN TWO MIDNIGHTS <input type="checkbox"/> CODE STATUS, FULL CODE |
| LAB <ul style="list-style-type: none"> <input type="checkbox"/> CBC, NOW <input type="checkbox"/> CBCD, NOW <input type="checkbox"/> BMP, NOW <input type="checkbox"/> CMP, NOW <input type="checkbox"/> PT/PTT, NOW <input type="checkbox"/> LIPID PANEL, NOW <input type="checkbox"/> CROSSMATCH, NOW <input type="checkbox"/> TYPE AND SCREEN, NOW <input type="checkbox"/> ANTIBODY SCREEN, NOW <input type="checkbox"/> SERUM HCG, NOW <input type="checkbox"/> URINE PREGNANCY, NOW <input type="checkbox"/> HGBAIC, NOW <input type="checkbox"/> MRSA SWAB, NOW (ALL IMPLANTS REQUIRE SWAB) <input type="checkbox"/> UA, CULTURE IF INDICATED, NOW | PATIENT CARE ORDERS <ul style="list-style-type: none"> <input type="checkbox"/> VITAL SIGNS UPON ADMISSION <input type="checkbox"/> ACTIVITY AS TOLERATED <input type="checkbox"/> INSERT LARGE BORE IV <input type="checkbox"/> OBTAIN CONSENT FOR SURGERY, IF NOT ALREADY COMPLETED <input type="checkbox"/> NPO _____ <input type="checkbox"/> CLEAR LIQUID DIET _____ |
| OTHER LABS <ul style="list-style-type: none"> <input type="checkbox"/> _____ | ANTIBIOTICS AND IV FLUIDS <ul style="list-style-type: none"> <input type="checkbox"/> HOLD ABX UNTIL AFTER CULTURES <input type="checkbox"/> ANCEF 1GM IVPB, NOW PREOP <input type="checkbox"/> ANCEF 2GM IVPB, NOW PREOP <input type="checkbox"/> CLINDAMYCIN 600MG IVPB, NOW PREOP <input type="checkbox"/> CLINDAMYCIN 900MG IVPB, NOW PREOP <input type="checkbox"/> VANCOMYCIN 1GM IVPB, NOW PREOP (IF ALLERGIC TO PENICILLIN) |
| RADIOLOGY EXAMS <ul style="list-style-type: none"> <input type="checkbox"/> XR CHEST 1 VIEW, REASON FOR EXAM = PREOP <input type="checkbox"/> XR CHEST 2 VIEWS, REASON FOR EXAM = PREOP | START NS AT: <input type="checkbox"/> 125ML/HOUR <input type="checkbox"/> 75ML/HOUR <input type="checkbox"/> START LR AT 125ML/HOUR <input type="checkbox"/> START D5LR AT 125ML/HOUR |
| TYPE OF CONTRAST FOR CT (IF NEEDED) <ul style="list-style-type: none"> <input type="checkbox"/> IV <input type="checkbox"/> PO | LABS <ul style="list-style-type: none"> <input type="checkbox"/> CBC, NOW <input type="checkbox"/> BMP, NOW <input type="checkbox"/> PT/PTT NOW <input type="checkbox"/> SERUM HCG NOW <input type="checkbox"/> URINE PREGNANCY, NOW |
| TYPE OF CT EXAM <ul style="list-style-type: none"> <input type="checkbox"/> CT CHEST WITH CONTRAST, REASON FOR EXAM = PREOP <input type="checkbox"/> CT ABDOMEN/PELVIS WITH CONTRAST, REASON FOR EXAM = PREOP <input type="checkbox"/> CT ABDOMEN W/WO CONTRAST, REASON FOR EXAM = PREOP <input type="checkbox"/> CT ABDOMEN WITHOUT CONTRAST, REASON FOR EXAM = PREOP | OTHER LABS <ul style="list-style-type: none"> <input type="checkbox"/> _____ |
| ULTRASOUND <ul style="list-style-type: none"> <input type="checkbox"/> US ABDOMEN LIMITED, REASON FOR EXAM = PREOP <input type="checkbox"/> US PELVIS NON – OB, LIMITED, REASON FOR EXAM = PREOP | RADIOLOGY EXAMS <ul style="list-style-type: none"> <input type="checkbox"/> XR CHEST 1 VIEW NOW, REASON FOR EXAM = PREOP <input type="checkbox"/> XR CHEST 2 VIEWS NOW, REASON FOR EXAM = PREOP |
| MRI <ul style="list-style-type: none"> <input type="checkbox"/> _____ | OTHER DIAGNOSTICS <ul style="list-style-type: none"> <input type="checkbox"/> _____ |
| OTHER <ul style="list-style-type: none"> <input type="checkbox"/> EKG, ONCE, PRE-OP <input type="checkbox"/> _____ <input type="checkbox"/> _____ | OTHER <ul style="list-style-type: none"> <input type="checkbox"/> _____ |



Summit Medical Center
 6350 E. 2nd Street
 Casper, WY 82609
 307-232-6600 Fax: 307-232-4071