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| **Location** | | | |
| ☐ Boise Surgery   **Fax: 208-381-3060** | ☐ Boise COU   **Fax: 208-381-3567** | ☐ Surgery Center Boise   **Fax: 208-381-3209** | ☐ Surgery Center Meridian   **Fax: 208-706-8102** |
| ☐ Boise Endo   **Fax: 208-381-2135** | ☐ Meridian Endo   **Fax: 208-706-5015** | ☐ Meridian Surgery   **Fax: 208-706-2178** | ☐ Wood River OR/Endo   **Fax: 208-727-8634** |
| ☐ Jerome   **Fax:** **208-324-7301** | ☐ McCall   **Fax:** **208-634-3818** | ☐ Magic Valley   **Fax: 208-814-2921** | ☐ Elmore   **Fax:** **208-580-9808** |
| ☐ Nampa   **Fax: 208-205-7486** |  |  |  |
| **Patient Name (First, middle initial and last):**   **Date of Birth:**  **Phone Number:**  **Case Number:**  **Date of Surgery:**  **Provider Name:**  **Weight:** kg **Height:** cm **Diagnosis:**  ☐ Interpretation Services; Language:  **Allergies:** | | | |

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| **Enhanced Surgical Pathway (Questions are required)** | | | | | | | |
| **Is this an ERAS patient?** | | | | | | | |
| ☐ Yes-This patient will follow a pathway for enhanced recovery after surgery (ERAS). The provider has given ERAS education to the patient. | | | | | | ☐ No | |
| ☐ NA-Emergent surgery, no ERAS education provided | |
| **Anticipated Discharge – Where do you plan for this patient to be discharged from?** | | | | | | | |
| ☐ Same Day – Discharge From Floor | | | | | | ☐ Same Day – Discharge From PACU | |
| ☐ Post-Op Day 1 | | | | | | ☐ Unknown | |
| **ERAS Diet Instructions** | | | | | | | |
| ☐ Ensure Pre-Surgery Drink | | | | ☐ Regular Sports Drink | ☐ Reduced Sugar Sports Drink | | ☐ Other: |
| **ERAS Bathing Instructions** | | | | | | | |
| |  |  | | --- | --- | | ☐ Chlorhexidine soap for showering | ☐ Personal soap for showering | | | | | | | | |
| **Ancillary Referrals (Pre-Admission Testing** | | | | | | | |
| ​​☐​ PAT Phone Call  ​​☐​ Pre-Admission Testing (PAT) Appointment Request  ​​☐​ Ambulatory Referral to Perioperative Medicine (Clinics – please complete Perioperative Medicine Consult Request Form, located at [www.stlukesonline.org/for-providers](http://www.stlukesonline.org/for-providers%20)  > Transferring and Referral) | | | | | | | |
| **Preadmission Testing ☐ N/A** | | | | | | | |
| ☐ CBC | | | | | | ☐ POCT Urine Pregnancy (Females age 12-55) | |
| ☐ APTT | | | | | | ☐ MRSA and SA Screen by PCR | |
| ☐ Protime-INR | | | | | | ☐ Type & Screen + ABOCAP if not filed in EHR | |
| ☐ Basic Metabolic Panel | | | | | | ☐ XR chest 2 view | |
| ☐ Comprehensive Metabolic Panel | | | | | | ☐ ECG 12 lead (obtain if no ECG results within 30 days) | |
| ☐ Glycohemoglobin A1C | | | | | | ☐ ECG 12 lead (obtain if no ECG results within 6 months) | |
| ☐ Hepatic Function Panel | | | | | | ☐ COVID-19 Symptomatic ☐ Priority 1 ☐ Priority 2 | |
| ☐ Urinalysis w/C&S if indicated | | | | | | ☐ COVID-19 Asymptomatic/Pre-procedure Screening  ☐ Priority 1 ☐ Priority 2 | |
| ☐ Other: | | | | | | | |
| **Admission (Pre-Op)** | | | | | | | |
| ☐ Admit to Inpatient ☐ Hospital Outpatient Surgery or Procedure (no bed) ☐ Hospital Outpatient Surgery or Procedure (with bed) | | | | | | | |
| **Telemetry:** ☐ No Telemetry ☐ Tele Unit ☐ Satellite Tele | | | | | | | |
| **Patient Name (First, middle initial and last): DOB:** | | | | | | | |
| **Code Status (Pre-Op)** | | | | | | | |
| |  |  |  | | --- | --- | --- | | ☐ Full Code | ☐ Modified code | ☐ DNR/DNI | | | | | | | | |
| **Diet (Pre-Op)** | | | | | | | |
| **☒** Adult NPO Diet, sips with meds | | | | | | ☐ Other: | |
| **Nursing (Pre-Op)** | | | | | | | |
| ☐ Clip and Prep Surgical Site | | | | | | ☐ Continuous Bladder Irrigation Panel | |
| **☒**Apply povidone iodine to both nares, once | | | | | | ☐ Manual Bladder Irrigation Panel | |
| **☒**  Verify Informed Consent (exact wording for surgery consent): | | | | | | | |
| **Labs (Pre-Op / Day of Surgery) ☐ N/A** | | | | | | | |
| ☐ CBC | | | ☐ Glycohemoglobin A1C | | | ☐ COVID-19 Asymptomatic/Pre-procedure Screening | |
| ☐ Protime-INR | | | ☐ Urinalysis w/C&S if Indicated | | | ☒ POCT blood glucose (Day of Surgery) | |  |
| ☐ Basic Metabolic Panel | | | ☐ MRSA and SA Screen by PCR nasal only | | | **☒** POCT urine pregnancy (Females age 12-55) | |
| ☐ Comprehensive Metabolic Panel | | |  | | |  | |
| ☐ Other: | | | | | |  | |
| **Blood Bank Tests and Products (Pre-Op)** | | | | | | | |
| ☐Type and Screen + ABOCAP if not filed in EHR  \*If preparing blood for a planned surgery, a Type and Screen needs to be resulted within 72 hours of product administration\* | | | | | | | |
| ☐ | Prepare RBC (Full Unit) ☐ 1 unit ☐ 2 units  ☐ Adult or Pediatric greater than 40 kg ☐ Pediatric less than 40 kg | | | | | **☒** Indications: Surgical Blood Product Supply  Request for special products: ☐ CMV Negative ☐ Irradiated | |
|  | Add’l Considerations: ☐ Crossmatch ☐ Emergent/Uncrossmatched | | | | | Donor source: ☒ Bank Units ☐ Directed Donor ☐ Autologous | |
| **Imaging (Pre-Op / Day of Surgery) ☐ N/A** | | | | | | | |
| ☐ | XR chest 2 view | | | | | ☐ XR abdomen1 vw | |
| **Procedures and Other Tests (Pre-Op) ☐ N/A** | | | | | | | |
| ☐ | | ECG 12 lead (obtain if no ECG results within 30 days) | | | | ☐ ECG 12 lead (obtain if no ECG results within 6 months) | |
| ☐ | | Other: | | | | | |

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| **Patient Name (First, middle initial and last): DOB:** | |
| **IV (Pre-Op)** | |
| **☒**  Initiate IV protocol - Adult | **☒** lactated ringers infusion at 25 mL/hr |
| **☒** Local Anesthetics  **☒** Sodium Chloride bacteriostatic 0.9% injection 0.1mL  **☒** Norflurane-pentafluoropropane (Pain Ease) topical spray 1 spray | ☐ sodium chloride 0.9% infusion at 25 mL/hr  ☐ Insert 2nd peripheral IV |
| **DVT/VTE Prophylaxis (pre-Op)** | |
| ☐ Sequential Compression Device **☒** Calf ☐ Thigh ☐ Foot pumps | ☐ No VTE Prophylaxis Anticoagulation Therapy Already Ordered |
| ☐ No Pharmacological VTE Prophylaxis -Reason for not ordering - | ☐ No VTE Prophylaxis-Patient Refused |
| ☐ No Mechanical VTE Prophylaxis- Reason for not ordering - | ☐ Consult to Pharmacy- Adjust medications for Renal Function |
| ☐ Heparin SQ, 5,000 units Once | ☐ Enoxaparin (Lovenox) SQ 30 mg, Once |
| **Antibiotics (Pre-Op) ☐ N/A** | |
| ☐ ampicillin (OMNIPEN) IV 2 g, Once, 1 hour prior to incision time | ☐ gentamicin (GARMYCIN) 5 mg/kg, IV, Once, administer over 60 minutes within one hour prior to incision time |
| ☐ cefoTEtan (CEFOTAN) IVPB 2 g, IV, Once, one hour prior to incision time | ☐ levofloxacin (LEVAQUIN) 500 mg/100mL IVPB ,500 mg, IV Once, Administer within one hour prior to incision time. |
| ☐ ceFAZolin (ANCEF) IVPB 2 g, IV, Once,1 hour prior to incision time | ☐ vancomycin (VANCOCIN) IVPB 15 mg/kg, IV, Once,1 hour prior to incision time |
| ☐ ceFAZolin (ANCEF) IVPB 3 g, IV Once,1 hour prior to incision time |  |
| ☐ clindamycin (CLEOCIN) IVPB 600 mg IV, Once,1 hour prior to incision time |  |
| ☐ ciprofloxacin (CIPRO) IVP premix, 400 mg, IV, Once,1 hour prior to incision time | ☐ Other: |
| **Multimodality Medications – These are multimodality medications to be administered in preop if not already prescribed and taken at home.** | |
| ☐ celebrex (celeBREX) capsule, PO, once prior to surgery ☐ 100 mg ☐ 200 mg | |
| ☐ Ibuprofen (ADVIL, MOTRIN) PO, once prior to surgery ☐ 200 mg ☐ 400 mg ☐ 600 mg ☐ 800 mg | |
| ☐ alvimopan (ENTEREG) PO, once prior to surgery ☐ 12 mg | |
| ☐ acetaminophen (TYLENOL) PO, once prior to surgery ☐ 250 mg ☐ 500 mg ☐ 1000 mg | |
| **Other Medications - Urinary** | |
| ☐ phenazopyridine (PYRIDIUM) tablet, 100 mg, PO, 1 hour prior to procedure  ☐ mitomycin (MUTAMYCIN) chemo bladder installation. 40mg, IntraVESICAL, Once, For intravesical infusion once to be administered intraoperatively: order pre-op to have available. Follow chemotherapy precautions, Preoperative.  ☐ gemcitabine (GEMZAR) chemo bladder instillation. IntraVESICAL, Once, For intravesical infusion once to be administered intraoperatively; order pre-op to have available. Follow chemotherapy precautions, Preoperative.  ☐ opium-balladonna (B&O #16A SUPPRETTES) 16.2-60 MG suppository. 1 suppository, Rectal, Once, To be administered intraoperatively; order pre-op so available, Preoperative  ☐ onabotulinumtoxinA (BOTOX) injection. 100 Units, IntraDETRUSOR, Once, Provider to administer, Preoperative | |

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| **Patient Name (First, middle initial and last):** | |  |
| **Anesthesia ☐ N/A** | | |
| ☐ Bier Block | ☐ N/A (No Anesthesia resource involved) | |
| ☐ Epidural | ☐ Regional Block | |
| ☐ General | ☐ SAB | |
| ☐ Local with Conscious Sedation (No Anesthesia Resource involved) | ☐ TBD by Anesthesia | |
| ☐ Local with NO Sedation (No Anesthesia Resource involved) | ☐ TIVA | |
| ☐ MAC | | |
| **Type of Optional Post-Op Analgesia ☐ N/A** Type of Optional Post-op analgesia requested to be completed by an Anesthesia provider. Anesthesia to perform block due to treatment technique beyond the experience of the operating physician.  **\*Indicate laterality if applicable** | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | ☐ | Adductor canal ☐ Right ☐ Left | ☐ | Bier Block ☐ Right ☐ Left | ☐ | Caudal | ☐ | Epidural | | ☐ | Fascia iliaca ☐ Right ☐ Left | ☐ | Femoral ☐ Right ☐ Left | ☐ | Interscalene ☐ Right ☐ Left | ☐ | Lower Extremity ☐ Right  ☐ Left | | ☐ | No nerve block | ☐ | Non-specified Brachial plexus block ☐ Right ☐ Left | ☐ | Paravertebral ☐ Right ☐ Left | ☐ | Peripheral Nerve Catheter  ☐ Right ☐ Left | | ☐ | Popliteal ☐ Right ☐ Left | ☐ | Rectus Sheath ☐ Right ☐ Left | ☐ | Saphenous ☐ Right ☐ Left | ☐ | Sciatic ☐ Right ☐ Left | | ☐ | Spinal with Morphine | ☐ | Transverse Abdominis plane ☐ Right ☐ Left | ☐ | Upper extremity ☐ Right ☐ Left | ☐ | Supraclavicular ☐ Right ☐ Left | | ☐ | Other : ☐ Right ☐ Left | | | | | | |   **\*Indicate laterality if applicable** | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | ☐ | Adductor canal ☐ Right ☐ Left | ☐ | Bier Block ☐ Right ☐ Left | ☐ | Caudal | ☐ | Epidural | | ☐ | Fascia iliaca ☐ Right ☐ Left | ☐ | Femoral ☐ Right ☐ Left | ☐ | Interscalene ☐ Right ☐ Left | ☐ | Lower Extremity ☐ Right  ☐ Left | | ☐ | No nerve block | ☐ | Non-specified Brachial plexus block ☐ Right ☐ Left | ☐ | Paravertebral ☐ Right ☐ Left | ☐ | Peripheral Nerve Catheter  ☐ Right ☐ Left | | ☐ | Popliteal ☐ Right ☐ Left | ☐ | Rectus Sheath ☐ Right ☐ Left | ☐ | Saphenous ☐ Right ☐ Left |  | Sciatic ☐ Right ☐ Left | | ☐ | Spinal with Morphine | ☐ | Transverse Abdominis plane ☐ Right ☐ Left | ☐ | Upper extremity ☐ Right ☐ Left | ☐ | Supraclavicular ☐ Right ☐ Left | | ☐ | Other: ☐ Right ☐ Left | | | | | | |   **\*Is there a secondary block?** ☐ Yes ☐No | | |
| **Additional Orders (any medication orders must include medication, dose, route, and phase of care) ☐ N/A** | | |
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| **PROVIDER SIGNATURE: DATE: TIME:** |