The Christ Hospital Surgery Center- **RED BANK**
GENERIC Pre-op Order Form 5/2010
Fax to (513) 272-7071
Surgeon name
Phone
Fax
THE FOLLOWING ABBREVIATIONS ARE NOT PERMITTED FOR USE:
IU,U (Units), QD (Daily), QOD (Every other day), 1.0 (1), .5 (0.5), MS, MSO4, MgSO4 (morphine sulfate, magnesium sulfate)

Patient Name :

Date of Birth

Surgery Date:

General Surgery Pre-op Testing To be performed within 30 days, unless otherwise noted.

H&P: ☐ per PCP ☐ per surgeon

☐ **General Anesthesia:**	**RN to check if criteria met**
If IDDM or greater than 50 years old	☐ 12 lead EKG- within 30 days of surgery
If greater than 75 years old	☐ EP1- within 30 days of surgery
If on Warfarin	☐ PT/INR- Day of surgery or day prior to surgery
If in Renal Failure	☐ Potassium –Day prior to surgery
If Diabetic	☐ Glucose on Admission
☐ **MAC Anesthesia:**	
If in Renal Failure	☐ Potassium –Day prior to surgery
If Diabetic	☐ Glucose on Admission
If on Warfarin	☐ PT - Day of surgery or day prior to surgery
☐ **Local anesthesia**	

☐ **General or MAC Anesthesia:** **RN to check if criteria met**
Urine pregnancy on day of surgery.
- ☐ If Female 11-55 yrs, unless pt has had a hysterectomy
- ☐ If Female less than 11 yrs. that has begun menses
- ☐ If Female greater than 55 yrs and is less than one year post-menopausal, unless pt has had a hysterectomy

Labs: ☐ CBC ☐ PT/INR ☐ PTT ☐ HgbAIC
☐ EP1 ☐ LDH ☐ LIVP ☐ Amylase ☐ Lipase ☐ Urinalysis
☐ Other: _____ ☐ Other: _____

☐ **EKG** reason: _____

X-ray: ☐ Chest PA & Lateral (within 6 months) ☐ Other: _____
Reason: _____

Surgery Same Day Orders **ALLERGIES:** _____ **Weight** _____

IV: ☐ Normal Saline @ 125 ml/hr; If CRF patient: NS @KVO
☐ Normal Saline 500 ml @ 50 ml/hr

☐ Void on call to OR

Antibiotics on call to OR:
☐ Cefazolin 1 Gram IVPB ☐ Cefazolin 2 Gram IVPB
If allergic, give
☐ Clindamycin 600mg IVPB ☐ Clindamycin 900mg IVPB
☐ Vancomycin 1 gram IVPB – Only with documented justification for use

☐ **Anti-embolism:**
TED hose ☐ Knee high ☐ Thigh high
SCD ☐ Knee high ☐ Thigh high
☐ Heparin _____units subcut

Physician Signature _____ Date/Time: _____

I HEREBY AUTHORIZE THE PHARMACY UNDER THE FORMULARY SYSTEM: TO DISPENSE A DIFFERENT BRAND OF DRUG OF IDENTICAL COMPOSITION AND COMPARABLE QUALITY OR AN APPROVED THERAPEUTIC EQUIVALENT UNLESS THE BRAND OR GENERIC NAME I HAVE PRESCRIBED IS ACCOMPANIED BY A NON-FORMULARY REQUEST FORM.