

KADLEC REGIONAL MEDICAL CENTER
888 SWIFT BLVD
RICHLAND, WA 99352
(509) 946-4611

PATIENT IDENTIFICATION

PRE-OPERATIVE REGISTRATION ORDERS

Patient Name: _____ Date of Birth: _____ Sex: M F

Diagnosis: _____ Authorization #: _____

Date of Procedure: _____ Type of Procedure: _____

Register Patient As: Inpatient Outpatient (anticipated length of recovery less than 4 hrs)
 Outpatient (anticipated length of recovery 4-24 hrs)
 Bloodless Program

Sedation: Anesthesiologist Physician

Allergies: _____

Pre-Operative Antibiotics on call to OR:

- | | | |
|---|--|---|
| <input type="checkbox"/> Cefazolin 1 gm IVPB | <input type="checkbox"/> Cefazolin 2 gm IVPB | <input type="checkbox"/> Vancomycin 1 Gm IVPB |
| <input type="checkbox"/> Cefoxitin 1 gm IVPB | <input type="checkbox"/> Cefoxitin 2 gm IVPB | Justification: <input type="checkbox"/> Ciprofloxacin 400 mg IVPB |
| <input type="checkbox"/> Cefuroxime 750 mg IVPB | <input type="checkbox"/> Cefuroxime 1.5 Gm IVPB | <input type="checkbox"/> Cefotetan 1 gm IVPB |
| <input type="checkbox"/> Unasyn 3 Gm IVPB | <input type="checkbox"/> Metronidazole 500 mg IVPB | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Clindamycin 600 mg IVPB | <input type="checkbox"/> Clindamycin 900 mg IVPB | |
| <input type="checkbox"/> Gentamicin _____ mg IVPB | | |

Venous Thromboembolism (VTE) Prophylaxis: PRE-OP ORDER General Surgery Patients:

Heparin 5,000 units SC 1-2 hours pre-op Enoxaparin 40 mg SC 1-2 hours pre-op

Unless contraindicated by: Active Bleeding Bleeding Risk Thrombocytopenia Patient refusal
 Other _____

After initial pre-op dose, refer to orders on the Venous Thromboembolism Prophylaxis/Initial Warfarin Order #0466.

If chemoprophylaxis contraindicated place: TEDs Knee TEDs Thigh SCDs/TEDs Calf SCDs/TEDs Thigh
 Foot Pumps/TEDs (option for orthopedic only)

Unless contraindicated by: Bilateral amputee Bilateral lower extremity trauma Patient Refusal
 Other _____

Skin Prep to Operative Site: (To be completed in the pre-op unit) NO SKIN PREP Hibiclens scrub

Technicare scrub Betadine scrub Chlor-a-prep Refer to pre-printed orders

Pre-Op Diagnostic Testing: None EKG CXR Other: _____

LABS:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> CBC | <input type="checkbox"/> CMP | <input type="checkbox"/> APTT | <input type="checkbox"/> Type & Screen |
| <input type="checkbox"/> UA | <input type="checkbox"/> Electrolyte Panel | <input type="checkbox"/> Protime | <input type="checkbox"/> Type & Cross _____ Units RBC |
| <input type="checkbox"/> BMP | <input type="checkbox"/> HCG | <input type="checkbox"/> Platelet Function Screen | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Initiate MRSA screening/treatment protocol | | | |

Initiate Adult Anesthesia Pre-Operative Protocol Anesthesia Consultation Discharge Planning Referral

ADDITIONAL PRE-OP ORDERS: Aspen Collar Soft Collar

Other: _____



1 3 0 0

Physician Signature: _____ Date: _____ Time: _____