GOOD SAMARITAN HOSPITAL
MEDICAL CENTER
WEST ISLIP, NY 11795

Patient Label

PRE-ADMISSION TESTING ORDERS

Physician Office – please <u>fax BOTH SIDES</u> of this form to 224-8783 within 24 hours of Pre-Surgical Testing Appt.

Today's Date: _____

*****ALL ENTRIES TO THE MEDICAL RECORD MUST INCLUDE DATE, TIME AND SIGNATURE*****
APPROVED THERAPEUTIC EQUIVALENT PRODUCTS WILL BE USED UNLESS OTHERWISE

The following abbreviations are **"UNACCEPTABLE"** and require written clarification when written:

U or IU (Write Units)	QOD (Write Every Other Day)	QD (Write Daily)	µg or ug (Write mcg)	MS or MSO4 (Write Morphine)	MgSO4 (Write Magnesium)	m and 3 (Use Metric)	Use Leading Zero (0.1mg)	Don't Use Trailing Zeros (1 mg)

Patient Name: _____ **Date of Birth**: _____/_____/_____

Telephone: Home _____ Business_____ Cell _____

Age: _____ **Sex**: Male☐ Female☐ **LMP**: _____ **Height**:_____ **Weight**:_____

Allergies:_____

Diagnosis Code: _____ **Date of Surgery/Procedure**: _____

Physician: _____ **Same Day Surgery** ☐ **Inpatient** ☐

Obtain Consent for: _____

☐**<u>Medical</u> Clearance by Dr.**_____ ☐**<u>Cardiac</u> Clearance by Dr.**_____

☐**Other Clearance by Dr.**_____ **Specialty:** _____

Labwork:

Age 6 months- 39 years	☐None (Males) ☐PT, PTT, INR	☐Hgb/Hct (females after onset menses)
Greater than 40 years	☐None ☐Hgb/Hct ☐BMP ☐Pulmonary Function Test/ABG **Inform patient to call the Respiratory Care Department at 376-4108 to schedule appointment prior to PST visit**	☐EKG ☐PT, PTT, INR ☐CBC
Women of Childbearing Potential	☐UCG * If the pregnancy test is completed 7 days prior to surgery date, a POC urine pregnancy Will be completed day of surgery (if patient unable to void a serum pregnancy test will be obtained).	☐Serum HBCG
Other Labwork: _____ ** Day of Procedure labwork according to Patient Safety Guidelines		

☐**Blood Bank** orders according to GSHMC Guidelines for elective surgery**.**

☐PST Staff to Notify Blood Bank if patient:

- **has received blood or blood products within 3 months**
- **has had miscarriage or pregnancy within 3 months**
- **has directed donation for procedure**
- **is a Jehovah Witness/unable to accept transfusions**

Radiology: ☐Chest X-Ray (Not required if pt. < 60 yrs. old or report from previous X-Ray within 12 months on chart)

Medication: **See PAGE 2- Antibiotic orders**

If patient on a daily morning Betablocker, confirm dose taken as prescribed the morning of surgery with a sip of water.

VTE Prophylaxis: Apply Intermittent Pneumatic Compression Device in O.R. unless contraindication listed below

Contraindication: _____

Other Orders: _____

_____

Physician Signature_____ **Date**_____ **Time**_____ **ID Number**_____

PST Nurse/NP Signature _____ **Date**_____ **Time**_____

GOOD SAMARITAN HOSPITAL
MEDICAL CENTER
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Patient Label

PHYSICIAN ORDERS FOR ADULT PRE-OP ANTIBIOTIC PROPHYLAXIS

Patient Name _____ Date of Birth_____ Height_____ Weight in kg _____ _____

Allergies_____ * **β-lactam allergy REACTION must be documented**

*****ALL ENTRIES TO THE MEDICAL RECORD MUST INCLUDE DATE, TIME AND SIGNATURE*****
APPROVED THERAPEUTIC EQUIVALENT PRODUCTS WILL BE USED UNLESS OTHERWISE INDICATED

The following abbreviations are **"UNACCEPTABLE"** and require written clarification when written:

U or IU (Write Units)	QOD (Write Every Other Day)	QD (Write Daily)	µg or ug (Write mcg)	MS or MSO4 (Write Morphine)	MgSO4 (Write Magnesium)	m and 3 (Use Metric)	Use Leading Zero (0.1mg)	Don't Use Trailing Zeros (1 mg)

Vancomycin Justification (Check ALL that apply): ☐ MRSA colonization ☐ Increased MRSA rate facility/community ☐ Chronic wound care/dialysis ☐ Inpatient hospitalization with in past 1 year ☐ Nursing Home Resident ☐ **SEVERE β-lactam allergy**

OPERATIVE PROCEDURE	ANTIMICROBIAL REGIMEN	Vancomycin Justification as above SEVERE β-lactam allergy Reaction: _____
Cardiac (i.e. Pacemaker, Defibrillator implant) **Vascular** (i.e. Arterial surgery involving prosthesis, abdominal aorta, groin incision, lower extremity amputation for ischemia)	☐ Cefazolin 1g IVPB	☐ Vancomycin 1g IVPB
Orthopedic and Podiatry	☐ Cefazolin 1g IVPB	☐ Vancomycin 1g IVPB
Colorectal	☐ Cefotetan 2g IVPB **OR** ☐ Ertapenem 1g IVPB	☐ Ciprofloxacin 400mg IVPB **and** Metronidazole 500mg IVPB
Upper Gastrointestinal – High Risk (esophageal, gastroduodenal, hernia repair with mesh) **High risk**: (Morbid obesity, esophageal obstruction, decrease in gastric acidity or GI motility)	☐ Cefazolin 1g IVPB	☐ Vancomycin 1g IVPB
Gynecologic and Obstetric (Vaginal, abdominal, or laparoscopic hysterectomy, C-Section)	☐ Cefotetan 2g IVPB	☐ Clindamycin 900mg IVPB **and** Gentamicin 1mg/kg=____mg IVPB
Synthetic Pubovaginal Sling	☐ Cefotetan 2g IVPB	☐ Clindamycin 900mg IVPB **and** Gentamicin 1mg/kg=____mg IVPB
Appendectomy (Non-perforated) Laparoscopic or Open	☐ Cefotetan 2g IVPB **OR** ☐ Ertapenem 1g IVPB	☐ Ciprofloxacin 400mg IVPB **and** Metronidazole 500mg IVPB
Biliary tract – High Risk (Cholecystectomy) **High risk:** (Age >70, acute cholecystitis, non-functioning gall bladder, CBD stones, obstructive jaundice)	☐ Cefazolin 1g IVPB	☐ Clindamycin 900mg IVPB **and** Gentamicin 1mg/kg = ____ mg IVPB **OR** ☐ Clindamycin 900mg IVPB **and** Ciprofloxacin 400mg IVPB
PEG Tube Placement/Revision	☐ Cefazolin 1g IVPB	☐ Vancomycin 1g IVPB **and** Ciprofloxacin 400mg IVPB
Genitourinary --- High Risk **High risk:** (Urine c/s positive or not available, pre-op catheter, transrectal prostatic biopsy)	☐ Ciprofloxacin 400mg IVPB **OR** ☐ Ciprofloxacin 500mg PO **OR** ☐ Ceftriaxone 1g IVPB	
Penile Prosthesis Insertion, Removal or Revision	☐ Piperacillin-tazobactam 3.375g IVPB	☐ Vancomycin 1g IVPB **and** Gentamicin 1mg/kg=_____mg IVPB
Head and Neck Surgery (Incisions through oral or pharyngeal mucosa)\	☐ Cefazolin 1g IVPB	☐ Clindamycin 900mg IVPB **and** Gentamicin 1.5mg/kg = ____ mg IVPB
Neurosurgery	☐ Cefazolin 1g IVPB	☐ Vancomycin 1g IVPB
Thoracic (Non-Cardiac)	☐ Cefazolin 1g IVPB	☐ Vancomycin 1g IVPB

Physician/NP/PA Signature_____ Date _____ Time_____ ID Number_____

ASU Nurse Signature: _____ Date _____ Time_____