Do Not Use Abbreviations: U (for Unit), IU for International unit), Q.D., Q.O.D., Trailing Zero (X.0 mg) MS, MSO4 MgSO4

PODIATRY/ORTHOPEDIC PRE-OPERATIVE ORDERS

Status: ☐ Admit to Inpatient Status (I certify that inpatient services are needed)
☐ Place Patient in Outpatient Status
☐ Place Patient in Outpatient Status and begin Observation Services

Admit to the service of:

PATIENT NAME (LAST):	FIRST NAME	DATE OF BIRTH:

DIAGNOSIS:	ANESTHESIA TYPE:

PROCEDURE CONSENT TO STATE:

DATE OF SURGERY/PROCEDURE	PHYSICIAN:	PRIMARY PHYSICIAN:

CPT CODE(S)

ALLERGIE(S)
Type of Reaction(s):
Patient Weight: __________ kg

PRE-OP MEDICATIONS:

IV FLUIDS:

☐ Lactated Ringers @ 30 mL/hr on arrival to Preop
☐ 0.9% Sodium Chloride @ 30 mL/hr on arrival to Preop
☐ ____

PRE-OP ANTIBIOTICS FOR GENERAL ORTHO/PODIATRY ONLY:

☐ Patient weight < 60 kg: cefazolin 1 gm IV, infuse within 60 minutes prior to surgery
☐ Patient weight 60-120 kg: cefazolin 2 gm IV, infuse within 60 minutes prior to surgery
☐ Patient weight > 120 kg: cefazolin 3 gm IV, infuse within 60 minutes prior to surgery

If beta-lactam allergy or has a history or risk for MRSA, give vancomycin; For *hip* or *knee* replacement, if positive or unknown MRSA nasal surveillance swab, *give cefazolin with vancomycin*:

Vancomycin Dose:

☐ Patient weight < 50 kg: Vancomycin 750 mg IV over 60 minutes, infuse within 120 minutes prior to surgery
☐ Patient weight 50 - 100 kg: Vancomycin 1 gm IV over 60 minutes, infuse within 120 minutes prior to surgery
☐ Patient weight > 100 kg: Vancomycin 1.5 gm IV over 90 minutes, infuse within 120 minutes prior to surgery

If beta-lactam and vancomycin intolerant, give clindamycin:

☐ Clindamycin 900 mg IV over 30 minutes, start 60 minutes prior to surgery

OTHER MEDICATIONS:

☐ Acetaminophen 975 mg PO x 1
☐ Celecoxib 200 mg PO x 1
☐ Celecoxib 400 mg PO x 1
☐ Gabapentin (Neurontin) 600 mg PO x 1
☐ Oxycodone SUSTAINED release (Oxycontin) 10 mg PO x1
☐ Oxycodone IMMEDIATE release (OxyIR) 10 mg PO x 1
☐ Metoclopramide 10 mg IV x 1

☐ Other medication order: ______________________
____
____
____
____
____
____

Physician Signature: ______________________ Print Name: ________________ Date/Time: ___/___/___ at: ______

PODIATRY-ORTHO
PRE OPERATIVE ORDERS

POS JFKN-701-10004
Rev. 12/17

5301 South Congress Avenue
Atlantis, FL 33462

Patient Identification/Label

PODIATRY/ORTHOPEDIC PRE-OPERATIVE ORDERS

☐ **EKG** Done at: ☐ JFK ☐ PCP
Must Be Legible Copy

Labs Done at: ☐ JFK
☐ Outside Testing

Please use Anesthesia Guidelines to determine testing.

☐ A1C
☐ CBC ☐ CBC With Differential
☐ Chem 7 ☐ PT, PTT & INR
☐ Chem 25 ☐ Liver Profile
☐ Sickle Cell ☐ BHCG < 55 yrs.
☐ Urinalysis ☐ CEA
☐ Urine Culture & Sensitivity
☐ Type & Screen
☐ MRSA/MSSA Screening (required for all total knees and total hips)
☐ Type & Cross X ___________ units

Other Labs: ____________________
____
____

☐ Anti Embolic Hose
☑ Sequential Compression Device(s)
☐ Incentive Spirometer

Case Management to Arrange:
☐ __________________________
☐ Rolling Walker

Medical Pre Op Evaluation: Phone:
☐ No ☐ Yes Dr.:

Cardiac Pre Op Evaluation: Phone:
☐ No ☐ Yes Dr.:

Other Pre Op Evaluation (Type): Phone:
☐ No ☐ Yes Dr.:

Other Pre Op Evaluation (Type): Phone:
☐ No ☐ Yes Dr.:

Patient From Nursing Home/Extended Care Facility? Phone:
☐No ☐ Yes Name:

☑ NPO AFTER MIDNIGHT, DATE:

☐ **Chest X-Ray**

☐ JFK ☐ Outside testing

MRI: ____________________________

CT: _____________________________

Obtain Test Results:

☐ OTHER _______________________

DONE AT : ______________________

ADDITIONAL ORDERS: ______________________________________
____
____
____
____
____

☐ Popliteal Block ☐ Single ☐ Catheter ☐ On Q Pump

PERSON COMPLETING FORM:	NAME (PLEASE PRINT): DATE: TIME:
PHYSICIAN'S SIGNATURE:	PHYSICIAN'S NAME (PLEASE PRINT): DATE: TIME:

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