**Orthopedic Pre Surgery Orders 2125 (MINOR)**

**R3592B**  Rev. 11/13/2018  Page 1 of 1

To be performed within 30 days, unless otherwise noted.

Fax to (513) 585-0169

**Patient Name:**  
**Date of Birth:**  
**Surgery confirmation #:**

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**Procedure Orders:**
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

**WEIGHT (kg):**  

<table>
<thead>
<tr>
<th><strong>ALLERGIES:</strong></th>
<th></th>
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<tbody>
<tr>
<td>☐ General/General Anesthesia</td>
<td>☐ Pre Admission Testing/Same Day Surgery RN to check if below criteria is met</td>
</tr>
<tr>
<td>☐ ECG required - within 6 months of surgery if:</td>
<td>☐ Diagnosis of: CAD, arrhythmia, CHF, CRF, arterial vascular disease, pulmonary disease (except asthma), or DM</td>
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<tr>
<td>☐ PT/INR day of surgery required – if no documented INR of 1.1 or less within 48 hours of surgery if on Warfarin in the last 30 days</td>
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<tr>
<td>☐ POCT Glucose day of surgery required – if diabetic, if blood glucose is less than 71 mg/dL (or less than 100 mg/dL and symptomatic) or if greater than or equal to 180 mg/dL, initiate Preop Diabetes/Glycemic Control Order Set and Notify Anesthesia.</td>
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<tr>
<td>☐ Potassium day of surgery required – if:</td>
<td>☐ 1) On dialysis or 2) Diagnosis of renal failure (not renal insufficiency or working transplant)</td>
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<td>☐ Urine pregnancy (Beta HCG if unable to void) on day of surgery, unless patient has negative serum pregnancy test within 7 days of surgery – required if female with no history of hysterectomy and:</td>
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<td>☐ 1) 11-55 years 2) Less than 11 years and has begun menses or 3) Greater than 55 years and less than one year post-menopausal</td>
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<tr>
<td>☐ IV: Insert Peripheral IV day of surgery (and saline lock if needed per anesthesia)</td>
<td>☐ Normal Saline @ 125 ml/hr (1000 ml bag) unless diagnosed with CRF then @ 50 ml/hr</td>
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<tr>
<td>☐ Other IV</td>
<td>☐ ☐ ☐</td>
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<tr>
<td>☐ Local Anesthesia</td>
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</tbody>
</table>

**Pre-operative consultation to evaluate for risk factors prior to surgery**  
☐ per PCP, may use hospitalists if not available  ☐ per hospitalist  ☐ per surgeon: date ________

**Request for anesthesia** to provide postoperative advanced pain management

**Nursing:**
☐ Notify MD of abnormal lab results  
☐ Celecoxib (Celebrex) does not need to be stopped prior to surgery. All other NSAIDs should be stopped 7 days before  
☐ Place TED hose on the non-operative leg preop and send the other TED with patient to OR  
☐ Please choose: ☐ Knee  ☐ Thigh

**Labs:**  
☐ CBC  ☐ Basic Metabolic Panel (EP1)  ☐ PT/INR  ☐ PTT  ☐ Urinalysis with reflex microscopic  
☐ Urine Culture

**Diagnostic Studies:**  
☐ Chest X-ray PA & Lateral (within 6 months of surgery date)  
☐ Other: __________________________  
| Reason: __________________________ | ☐ ECG Reason: __________________________ |

**VTE Mechanical Prophylaxis (REQUIRED):**
☐ Place SCD prior to induction of anesthesia  ☐ Knee  ☐ Thigh  ☐ Foot  ☐ Right  ☐ Left  ☐ Bilateral  
☐ NO SCD needed-must give reason  ☐ Already anticoagulated  ☐ Ambulating  ☐ Patient Refused  ☐ Fall risk  ☐ Not indicated-low clinical risk

**VTE Pharmacological Prophylaxis (OPTIONAL):**
☐ Heparin 5,000 units, subcutaneous, preop once  
☐ No pharmacologic VTE  ☐ Already anticoagulated  ☐ Bleeding risk  ☐ Active bleeding  ☐ Patient Refused  ☐ Thrombocytopenia  
☐ Not-indicated-low clinical risk

**No preop antibiotics needed**

**Pre-Operative Antibiotics:** *Required – *ORIF, or other *(CHOOSE ONE)*  
☐ Cefazolin 2 g IVPB x1; if patient greater than or equal to 120 kg Cefazolin 3 g IVPB x1;  
☐ Alternate if allergy give Clindamycin 900 mg IVPB  
☐ OR  
☐ History of MRSA infection: Vancomycin 15 mg/kg IVPB (15 mg/kg Intravenous, PRE-OP ONCE, Pre-op (day of surgery)  
☐ Other __________________________

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Physician Signature __________________________  Date: __________ Time: __________