Renal Access Pre-Surgery Orders

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To be performed within 30 days, unless otherwise noted.
Fax to (513) 585-0169

Surgeon Name: _____
Phone: _____
Fax: _____

Patient Name : _____

Date of Birth : _____

Surgery confirmation # _____

Procedure Orders: _____

_____

WEIGHT (kg): _____ **ALLERGIES:** _____

Before Day of Surgery:

Preoperative consultation to evaluate for risk factors prior to surgery and to include review of systems:

☐ Per PCP (may use PSOC NP if not available) ☐ Per Surgeon ☐ Per Hospitalist (for add-on/emergent cases only)

☐ H&P not required for local anesthesia cases

Labs: ☐ PT/INR ☐ PTT ☒ ALL testing can be performed stat dos

Diagnostic Tests/Imaging Studies: ☐ Chest X-ray PA & Lateral ☐ EKG

Day of Surgery:

☐ **General/MAC/Regional Anesthesia Preop:**

Insert Peripheral IV (and saline lock if needed per Anesthesia)

Sodium Chloride 0.9% 1000 ml @ 125 ml/hr IV. (Reduce rate to 50 ml/hr if diagnosis of chronic renal failure)

☐ **Local Anesthesia with Sedation by Surgeon:**

Insert Peripheral IV

Sodium Chloride 0.9% 100 ml @ 125 ml/hr. (Reduce rate to 50 ml/hr if diagnosis of chronic renal failure)

☐ **Local Anesthesia**

Nursing Orders:

☒ Apply mepilex pressure relief overlay to coccyx - ***Required for surgery 4 hours or longer**

☐ Void On Call to OR

☐ No additional Dexamethasone or steroids by Anesthesia

☐ Obtain Vein Mapping or previous OR record if available

☐ Consult Pre op Anesthesia: Request for anesthesia to provide postoperative advanced pain management

VTE Mechanical Prophylaxis:

☐ Place SCD prior to induction of anesthesia ☐ Knee ☐ Thigh ☐ Right ☐ Left ☐ Bilateral

☐ No SCD needed-must give reason ☐ Already Anti-coagulated ☐ Ambulating ☐ Refused

☐ Fall Risk ☐ Not indicated-low clinical risk

VTE Pharmacologic Prophylaxis:

☐ Heparin 5,000 units Subcutaneous X1 pre op

☐ No pharmacologic VTE-must give reason ☐ Already Anti-coagulated ☐ Comfort measures only

☐ Refused ☐ Bleeding Risk ☐ Active Bleeding ☐ Not indicated-low clinical risk

☐ **No Pre op Antibiotic Needed**

Pre-operative Antibiotics:

***Required-*AV Fistula, *Dialysis Catheter Removal, *Amputation**

☐ Cefazolin 2g IVPB preop X1 if patient greater than or equal to 120kg Cefazolin 3g IVPB preop X1 **Alternate if Cephalosporin allergy:** Clindamycin 900 mg IVPB X1

Peritoneal Dialysis Catheter Placement

☐ Vancomycin 15 mg/kg IVPB pre op X1 **Alternate if allergy** give Cefazolin 2g IVPB X1 pre op

Physician Signature _____ Date: _____ Time: _____

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