|  |
| --- |
| **Location** |
| [ ]  Boise Surgery  **Fax: 208-381-3060** | [ ]  Boise COU  **Fax: 208-381-3567** | [ ]  Surgery Center Boise  **Fax: 208-381-3209** | [ ]  Surgery Center Meridian  **Fax: 208-706-8102** |
| [ ]  Boise Endo  **Fax: 208-381-2135** | [ ]  Meridian Endo  **Fax: 208-706-5015** | [ ]  Meridian Surgery  **Fax: 208-706-2178** | [ ]  Wood River OR/Endo  **Fax: 208-727-8634** |
| [ ]  OSC – River Street  **Fax: 208-336-1954** |  | [ ]  Magic Valley  **Fax: 208-814-2921** | [ ]  Elmore  **Fax:** **208-580-9808** |
| [ ]  Jerome  **Fax:** **208-324-7301** | [ ]  McCall  **Fax:** **208-634-3818** | [ ]  Nampa  **Fax: 208-205-7486** |  |
| **Patient Name (First, middle initial and last):**   **Date of Birth:**  **Phone Number:**  **Case Number:**  **Date of Surgery:**  **Provider Name:**   **Diagnosis:** **Weight:** kg **Height:** cm **Allergies:**  [ ]  Interpretation Services; Language:  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|

|  |
| --- |
| **Enhanced Surgical Pathway**  |
| **Anticipated Discharge – Where do you plan for this patient to be discharged from?**  |
| [ ]  Same Day – Discharge From Floor Same Day – Discharge From Floor  | [ ]  Same Day – Discharge From PACUSame Day – Discharge From PACU |
| [ ]  Post-Op Day 1Post-Op Day 1 | [ ]  UnknownUnknown |

**Ancillary Referrals (Pre-Admission Testing)**  |
| ​​☐​ PAT Phone Call ​​☐​ Ambulatory Referral to Pre-Admission Testing Clinic ​​☐​ Ambulatory Referral to Perioperative Medicine (Clinics – please complete Perioperative Medicine Consult Request Form, located at [www.stlukesonline.org/for-providers](http://www.stlukesonline.org/for-providers%20)  > Transferring and Referral) |
| **Pre Admission Testing** [ ]  **N/A**  |
|[ ]  CBC  |[ ]  Glycohemoglobin A1C  |[ ]  Type & Screen + ABOCAP if not filed in EHR |
|[ ]  APTT |[ ]  Hepatic Function Panel  |[ ]  XR chest 2 view |
|[ ]  Protime-INR  |[ ]  Urinalysis w/C&S if indicated  |[ ]  ECG 12 lead (obtain if no ECG within 30 days) |
|[ ]  Basic Metabolic Panel |[ ]  POCT Urine Pregnancy |[ ]  ECG 12 lead (obtain if no ECG within 6 months) |
|[ ]  Comprehensive Metabolic Panel |[ ]  MRSA and SA Screen by PCR |[ ]  COVID-19 Symptomatic [ ]  Priority 1 [ ]  Priority 2 |
|[ ]  Other:  |[ ]  COVID-19 Asymptomatic/Pre-procedure Screening [ ]  Priority 1 [ ]  Priority 2 |
| **Admission**  |
| [ ]  Admit to Inpatient  | [ ]  | Hospital Outpatient Surgery (no Bed)  | [ ]  | Hospital Outpatient Surgery (with bed) |
|

|  |
| --- |
| **Telemetry:**  [ ]  No Telemetry [ ]  Tele Unit [ ]  Satellite Tele |
| **Code Status (Pre-Op)**  |

|  |  |  |
| --- | --- | --- |
|[ ]  Full Code  |[ ]  Modified code  |[ ]  DNR/DNI |

 |
| **Diet (Pre-Op)** |
|[x]  Adult NPO Diet |[ ]  Other:  |
| **Nursing (Pre-Op)**  |
| [x]  | Sequential compression device [x]  Calf [ ]  Thigh  | [ ]  | Clean surgical site with chlorhexidine wipes (do not apply to open skin)  |
| [x]  | Clip and Prep Surgical Site  |[ ]  Insert Indwelling Urinary Catheter, Reason: Pre-Surgery/Pre-Procedure |
| [ ]  | Apply povidone iodine 5% to both nares  |
|  |
| **Patient Name (First, middle initial and last): DOB:**  |
|[x]  Verify informed Consent (exact wording for surgery consent):  |
| **Labs (Pre-Op / Day of Surgery)** [ ]  **N/A** |
|[ ]  CBC  |[ ]  Comprehensive Metabolic Panel  |[ ]  MRSA and SA Screen by PCR nasal only |
|[ ]  APTT  |[ ]  Glycohemoglobin A1C |[x]  POCT blood glucose – For all Diabetic Patients  |
|[ ]  Protime-INR  |[ ]  Urine HCG Screen |[x]  POCT urine pregnancy (Females age 12-55) |
|[ ]  Basic Metabolic Panel |[ ]  Urinalysis w/C&S if Indicated |[ ]  COVID-19 Symptomatic [ ]  Priority 1 [ ]  Priority 2 |
|[ ]  Other:  |[ ]  COVID-19 Asymptomatic/Pre-procedure Screening [ ]  Priority 1 [ ]  Priority 2 |
| **Blood Bank Tests and Products (Pre-Op)** |
|[ ]  Type and Screen + ABOCAP if not filed in EHR\*If blood is for a planned surgery, a Type and Screen needs to be resulted within 72 hours of product administration\* |
|[ ]  Prepare RBC (Full Unit) [ ]  1 unit [ ]  2 units[ ]  Adult or Pediatric greater than 40 kg [ ]  Pediatric less than 40 kg | [x]  Indications: Surgical Blood Product SupplyRequest for special products: [ ]  CMV Negative [ ]  Irradiated |
|  | Additional Considerations: [ ]  Crossmatch [ ]  Emergent/Uncrossmatched |  Donor source: [x]  Bank Units [ ]  Directed Donor [ ]  Autologous |
| **Imaging and Other Tests (Pre-op)** [ ]  **N/A** |
|[ ]  XR Chest 2 View, Pre-Operative |
|[ ]  ECG 12 lead (obtain if no ECG results within 30 days)  | [ ]  ECG 12 lead (obtain if no ECG results within 6 months) |
| **Specialty Consults (Pre-Op)** [ ]  **N/A** |
| [ ]  | IP Consult to Anesthesiology | Reason for referral:  |
| [ ]  | IP Consult to Hospitalists | Reason for referral:  |
| [ ]  | IP Consult to Internal Medicine | Reason for referral:  |
| **IV (Pre-Op)**  |
| [x]  | Initiate IV protocol – Adult  |  |  |[x]  lactated ringers at 25 mL/hr |
| [x]  | Local Anesthetics: [x]  Sodium Chloride bacteriostatic 0.9% injection 0.1mL  [x] Norflurane-pentafluoropropane (Pain Ease) topical spray 1 spray |[ ]  sodium chloride 0.9% at 25 mL/hr |
|  |  |  |  |[ ]  Other:  |
|  |  |  |  |  |  |
| **Patient Name (First, middle initial and last): DOB:**  |
| **Antibiotics (Pre-Op)** [ ]  **N/A** |
| [ ]  | ceFAZolin (ANCEF) IVPB 2 g x 1 dose; one hour prior to incision time |
| [ ]  | ceFAZolin (ANCEF) IVPB 3 g x 1 dose; one hour prior to incision time |
|[ ]  Ceftriaxone (ROCEPHIN) IV 2,000mg , Once, one hour prior to incision time |
|[ ]  clindamycin (CLEOCIN) IVPB 900 mg x 1 dose; one hour prior to incision time |
|[ ]  piperacillin-tazobactam (ZOSYN) IVPB 3.375 g x 1 dose; one hour prior to incision time  |
|[ ]  ampicillin-sulbactam (UNASYN) IVPB 3 g x 1 dose; one hour prior to incision time |
|[ ]  levofloxacin (LEVAQUIN) IV 500 mg x 1 dose; one hour prior to incision time |
|[ ]  metronidazole (FLAGYL) IVPB 500 mg x 1 dose; one hour prior to incision time |
|[ ]  cefoTEtan (CEFOTAN) IVPB 2 g x 1 dose; one hour prior to incision time |
|[ ]  vancomycin (VANCOCIN) IVPB 15 mg/kg x 1 dose; two hours prior to incision time |
|[ ]  Other:  |
| **Pain Medications (Pre-Op)** [ ]  **N/A** |
| [ ]  | oxyCODONE (OXYCONTIN) ER tablet 10 mg Once, Oral, For 1 Doses, Preoperative |
| [ ]  | pregabalin (LYRICA) capsule 75 mg Once, Oral, For 1 Doses, Preoperative |
| [ ]  | celecoxib (celeBREX) capsule 100 mg Once, Oral, For 1 Doses, Preoperative |
| [ ]  | acetaminophen (TYLENOL) tablet 1,000 mg Once, Oral, For 1 Doses, Preoperative |
| [ ]  | Other:  |
| **Zynrelef OR Exparel and REC solution (Cannot select Zynrelef and Exparel to ensure patient does not receive excess Bupivacaine** |
|

|  |  |
| --- | --- |
| [ ]  | Bupivacaine-meloxicam (Zynrelef) instillation (400 mg – 12 mg/14 mL instillation) – ONLY for joint patientsIs this being used for THA/TKA? [ ]  Yes |
| **OR** |  |
| [ ]  | Bupivacaine liposome (PF) (Exparel) infiltration suspension (1.3% - 13.3mg/mL) |
|  | **With (optional):** |
| [ ]  | Ropivacaine-EPINEPHrine-cloNIDine injection (Ropivacaine 90 mg, EPINEPHrine 0.5 mg, cloNIDine 80 mcg (REC)) once, Pre-operative [x]  IntraARTICULAR [ ]  Local Infiltration [ ]  Infiltration  |
| [ ]  | Ropivacaine-EPINEPHrine-cloNIDine + **ketorolac** injection (ketorolac 30 mg in ropivacaine 90 mg, EPINEPHrine 0.5 mg, cloNIDine 80 mcg) once, Pre-operative [x]  IntraARTICULAR [ ]  Local Infiltration [ ]  Infiltration |
| [ ]  | Ropivacaine-EPINEPHrine-cloNIDine + **fentaNYL** injection (fentaNYL 100 mcg in ropivacaine 90 mg, EPINEPHrine 0.5 mg, cloNIDine 80 mcg) once, Pre-operative [x]  IntraARTICULAR [ ]  Local Infiltration [ ]  Infiltration |
| [ ]  | Ropivacaine-EPINEPHrine-cloNIDine + **ketorolac** + **fentaNYL** injection (ketorolac 30 mg, fentaNYL 100 mcg in ropivacaine 90 mg, EPINEPHrine 0.5 mg, cloNIDine 80 mcg) once, Pre-operative [x]  IntraARTICULAR [ ]  Local Infiltration [ ]  Infiltration |

 |
| **Local Anesthetics** |
| [ ]  | Mepivacaine (Carbocaine) (PF) Injection 60mg Intrathecal |
| **Anticoagulants (Pre-Op)** [ ]  **N/A** |
|[ ]  Heparin subcutaneous injection 5,000 units x 1 dose  |[ ]  Enoxaparin (Lovenox) subcutaneous injection 30 mg x 1 dose |
|[ ]  Heparin subcutaneous injection 7,500 units x 1 dose |[ ]  Enoxaparin (Lovenox) subcutaneous injection 40 mg x 1 dose |
|  |  |  |  |
| **Patient Name (First, middle initial and last): DOB:**  |
| **Tranexamic Acid Panel** [ ]  **N/A****\*Contraindicated in patients with a history of: Allergy/sensitivity to TXA, Active thromboembolic disease, Seizures, Acquired defective (impaired) color vision. Use caution in " High Risk Patients" with a history of: CVA, DVT/PE, Coronary artery stent, compromised renal function/renal insufficiency.**  |
| [ ]  | tranexamic acid (CYKLOKAPRON) 1,000 mg in sodium chloride 0.9 % 100 mL IVPB-V2B 1,000 mg Once, IntraVENOUS, for 30 Minutes, For 1 Doses, Administer in pre-op. Preoperative |
| [ ]  | tranexamic acid (CYKLOKAPRON) 1,000 mg in sodium chloride 0.9 % 100 mL IVPB-V2B 1,000 mg Once, IntraVENOUS, for 30 Minutes, For 1 Doses, Administer at close of incision. Preoperative |
| [ ]  | tranexamic acid (CYKLOKAPRON) 1,000 mg in sodium chloride 0.9 % 100 mL IVPB-V2B 1,000 mg Once, IntraVENOUS, for 30 Minutes, For 1 Doses, Administer in PACU. PACU |

|  |
| --- |
| **Anesthesia** [ ]  **N/A** |
|[ ]  Bier Block |[ ]  MAC |[ ]  TIVA |
|[ ]  Epidural |[ ]  N/A (No Anesthesia resource involved) |
|[ ]  General |[ ]  Regional Block |
|[ ]  Local with Conscious Sedation (No Anesthesia Resource involved) |[ ]  SAB |
|[ ]  Local with NO Sedation (No Anesthesia Resource involved) |[ ]  TBD by Anesthesia |
|  |  |  |  |
| **Type of Optional Post-Op Analgesia** [ ]  **N/A** |
|[ ]  Adductor canal |[ ]  Bier Block  |[ ]  Caudal |[ ]  Epidural |
|[ ]  Fascia Iliaca |[ ]  Femoral |[ ]  Interscalene  |[ ]  Lower Extremity |
|[ ]  No nerve block |[ ]  Non-specified Brachial plexus block |[ ]  Paravertebral |[ ]  Peripheral Nerve Catheter |
|[ ]  Popliteal |[ ]  Rectus Sheath |[ ]  Saphenous |[ ]  Sciatic |
|[ ]  Spinal with Morphine  |[ ]   Transverse Abdominis plane  |[ ]  Upper extremity |
|[ ]  Other:  |
| **Additional Orders (any medication orders must include medication, dose, route and phase of care)** [ ]  **N/A** |
|   |

|  |
| --- |
| **PROVIDER SIGNATURE: DATE: TIME:** |