HSHS St. John's Hospital

SURGERY SCHEDULING/ PHYSICIAN ORDER

Main & OSC
217-757-6060 **Phone**
Fax all preadmission information to 217-757-6018

Cardiac Surgery
1-866-466-8707(press 1) **Phone**
217-544-6464, ext. 50501 **Local Phone**
Fax all preadmission information to 217-757-6008

Surgery Suites
217-544-6464, ext. 50300 **Phone**
Fax all preadmission information to 217-757-6494

Tracking #__________________ Issued by __________________

Procedure date:____/____/_____ Patient status: ☐ Outpatient ☐ AM admission (IP)

Surgeon: ________________________________Length of procedure: ______ hrs

Time: ________________________________ TF: ____________________________

Procedure(s) / consent for: ____

☐ Bilateral ____

☐ Left ____

☐ Right ____

☐ Levels ________________ CPT Code: ____________________

Positioning: ____________________________ OR table: ____________________

Supplies/System/Equipment requests: ____________________________________

____

Check all that apply:

- ☐ Latex allergy
- ☐ MRO
- ☐ VRE
- ☐ Needle loc_____ (time)
- ☐ MRI_______ (time)
- ☐ CT _________ (time)
- ☐ Nuc Med _______ (time)
- ☐ SSEP
- ☐ Ultrasound
- ☐ Cell saver
- ☐ Translator

Rep. notified: ☐ Yes ☐ No ☐ N/A

Anesthesia type: ☐ General ☐ Local ☐ Monitored anesthesia care ☐ Bier Block ☐ Spinal/Epidural ☐ Anesthesia choice

☐ Post-op pain block requested by surgeon Post-op level of care: ☐ General ☐ IMC ☐ ICU

Patient name: ____ ☐ Male ☐ Female
(First) (MI) (Last)

DOB:____/____/_____ Social Security #_______-_______-__________ Email: ____________________________

Home address: ____

Phone# : ______________________________

Insurance carrier:____ Precert #: ______________________

If Medicare/Medicaid, length of stay:_____ Ht:_______ Wt:______ BMI:_____

Allergies/Adverse reactions: ____

Films to be brought by: ☐ Physician ☐ Nurse ☐ Resident ☐ Patient

PRE-OP TESTING

- ☐ Anesthesia Protocol
- ☐ EKG
- ☐ Chest X-ray
- ☐ CBC w/diff
- ☐ BMP
- ☐ CMP
- ☐ MG
- ☐ PT/INR
- ☐ PTT
- ☐ U/A
- ☐ Urine C&S
- ☐ UHCG
- ☐ Nasal swab for MRSA within 14 days
- ☐ Type & screen (if antibodies present, proceed to a Type & Cross)
- ☐ Type & cross _____units within 14 days
- ☐ Other: ____________________

Testing location:______________

Physician for H&P:______________________________ Phone: ______________

Primary Physician:______________________________ Phone: ______________

Hospitalist Service: ☐ HSHS ☐ SIU ☐ Springfield Clinic Reason:_______________

Cardiologist:___________________________________ Phone: ______________

Pre-op diagnosis ________________________ ICD-10 code: ______________

ADMIT ORDERS:

Pre-Op Antibiotics ____________________________ ☐ On call to OR ☐ None

☐ NPO p midnight ☐ CHG wipes

Order set to be used:____________________Pre-Op order set to be used: ________________

Hold ACE inhibitors 24 hrs prior to surgery.
Beta Blockers: Instruct patient to take beta blockers as prescribed day of surgery.

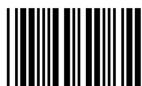
FAX ALL PRE-ADM. ORDERS, H&P, CONSENTS AND TESTING RESULTS WITH THIS FORM.

Office Task List

- ☐ Scheduler ☐ Insurance
- ☐ Vascular Lab, Nuc Med, EEG, Needle loc

PHYSICIAN SIGNATURE: ______________________________ **DATE:**__________ **TIME:** ______________

OEYPHYORD A8395
Rev. 03/07/2019



JZ

Patient name: ____
First *MI* *Last*

DAY OF SURGERY PRE-OPERATIVELY ANTIBIOTIC ORDERS:

______ cefazolin (ANCEF®) 2 Gm IVPB once within 1 hr prior to surgical incision if Pt. wt less than 120 Kg. **Administer only if Pt. is not allergic to penicillin/cephalosporin drug family.** Do not give to revision cases until surgeon approves order.

______ cefazolin (ANCEF®) 3 Gm IVPB once within 1 hr prior to surgical incision if Pt. wt greater than 120 Kg. **Administer only if Pt is not allergic to penicillin/cephalosporin drug family.** Do not give to revision cases until surgeon approves order.

______ clindamycin phosphate 900 mg IVPB once within 1 hr prior to surgical incision. **If patient allergic to penicillin/cephalosporin drug family.** Do not give to revision cases until surgeon approves order.

______ vancomycin hydrochloride 15 mg/Kg, IVPB once within 2 hrs prior to surgical incision, maximum dose of 2000 mg

Reason for vancomycin:

_____ Beta-lactam (penicillin or cephalosporin) allergy

_____ Documented MRSA colonization

DAY OF SURGERY PRE-OPERATIVE MEDICATION ORDERS:

______ celecoxib (CELEBREX®) 200 mg Po with sip of water; if Pt. allergic to sulfa, give meloxicam (MOBIC®) 7.5 mg Po with sip of water; St. John's pain protocol recommended

______ acetaminophen (TYLENOL®) 1000 mg Po with sip of water; St. John's pain protocol recommended

______ dexamethasone 10 mg IV push x1 dose; St. John's pain protocol recommended

______ tramadol hydrochloride (ULTRAM®) 100 mg Po with sip of water

______ oxycodone hydrochloride (OXYCONTIN®) 10 mg Po with sip of water (Pt. greater than 65 and no Hx of sleep apnea)

______ oxycodone hydrochloride (OXYCONTIN®) 20 mg Po with sip of water (Pt. less than 65 and no Hx of sleep apnea)

______ gabapentin (NEURONTIN®) 300 mg Po with sip of water

______ aprepitant (EMEND®) 40 mg Po with sip of water

______ ondansetron (ZOFRAN®) 4 mg IV push on call to OR

______ tranexamic acid (TXA) 1 gm IV in 50 mL sodium chloride 0.9% **IVPB** on call to OR. Administer 30 minutes prior to incision

______ tranezamic acid (TXA) 1 gm IV in 50 mL sodium chloride 0.9%. On call to OR, to be applied **topically** to incision during operative procedure, if patient has history of stroke, DVT, stent

______ bactroban nasal (for MRSA [+] swab) one application to each nare b.i.d. x 5 days

Beta Blockers: Instruct patient to take beta blockers as prescribed day of surgery.

Key:	
TF = to follow	MRO = Multi-resistant organisms
loc = localization	VRE = vancomycin-resistant enterococci
	Nuc Med = Nuclear Medicine
	SSEP – Somatosensory Evoked Potential

FAX ALL PRE-ADM. ORDERS, H&P, CONSENTS AND TESTING RESULTS WITH THIS FORM.

PHYSICIAN SIGNATURE: ______________________ **DATE:**__________ **TIME:** __________

SURGERY SCHEDULING/PHYSICIAN ORDER