|  |  |  |  |
| --- | --- | --- | --- |
| **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** |
| COSM –  **Fax: 208-706-1839** |  | 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:**   **Allergies:**  **Weight:** kg **Height:** cm **Diagnosis:**  Interpretation Services; Language: | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Pre Admission Testing  N/A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | CBC | | | | | | | | | | | | |  | | | | APTT | | | | | | | | | | | | | | | |  | | | Protime-INR | | | | | | | | | | | | |
|  | Basic Metabolic Panel | | | | | | | | | | | | |  | | | | Comprehensive Metabolic Panel | | | | | | | | | | | | | | | |  | | | Glycohemoglobin A1C | | | | | | | | | | | | |
|  | Hepatic Function Panel | | | | | | | | | | | | |  | | | | Urinalysis w/C&S if Indicated | | | | | | | | | | | | | | | |  | | | MRSA and SA Screen by PCR | | | | | | | | | | | | |
|  | COVID-19 Asymptomatic/Pre-procedure Screening | | | | | | | | | | | | |  | | | | Type & Screen + ABOCAP if not filed in EHR | | | | | | | | | | | | | | | |  | | | Other: | | | | | | | | | | | | |
| **Admission** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Admit to Inpatient  Hospital Outpatient Surgery or Procedure (no Bed) | | | | | | | | | | | | | | | | | | | | | | | | | | | Hospital Outpatient Surgery or Procedure (with Bed) | | | | | | | | | | | | | | | | | | | | | |
| **Code Status (Pre-Op)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Full code | | | | | | |  | | Modified code | | | | | | | | | | | | | | | | | |  | | | DNR/DNI | | | | | | | | | | | | | | | | | | |
| **Diet (Pre-Op)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Pediatric NPO Diet | | | | | | | | | | | | | | | | | | | | |  | | Other: | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nursing (Pre-Op)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Sequential compression device – Calf | | | | | | | | | | | | | | | | | | | | |  | | Insert Indwelling Urinary Catheter; Reason: Pre-Surgery/Pre-Procedure | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Verify informed Consent (exact wording for surgery consent): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Labs (Pre-Op / Day of Surgery)  N/A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | CBC | | | | | | | | | | | | | | | | | | | | |  | | Urine Culture | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Basic Metabolic Panel | | | | | | | | | | | | | | | | | | | | |  | | Urine HCG Screen | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Comprehensive Metabolic Panel | | | | | | | | | | | | | | | | | | | | |  | | MRSA abd SA Screen by PCR nasal only | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Glycohemoglobin A1C | | | | | | | | | | | | | | | | | | | | |  | | POCT blood glucose (For all Diabetic Patients) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Urinalysis w/C&S if Indicated | | | | | | | | | | | | | | | | | | | | |  | | POCT urine pregnancy (Females age 12-55) | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Other: | | | | | | | | | | | | | | | | | | | | |  | | COVID-19 | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Blood Bank Tests and Products (Pre-Op)  N/A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ☐ | Type and Screen + ABOCAP if not filed in HER  \*If preparing blood 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  10 mL/kg  Adult or Pediatric greater than 40 kg  Pediatric less than 40 kg | | | | | | | | | | | | | | | | | | | | | | | | | | | Indications: Surgical Blood Product Supply  Request for special products:  CMV Negative  Irradiated | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  | | --- | --- | --- | |  | Add. Considerations  Crossmatch  Emergent/Uncrossmatched | Donor source  Bank Units  Directed Donor  Autologous | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Imaging and Procedures (Pre-Op / Day of Surgery)  N/A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | XR chest 2 view | | | | | | | | | | | | | | | | | | | |  | | Other:  **PROVIDER  INITIALS:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | ECG 12 lead | | | | | | | | | | | | | | | | | | | |  | | Echo Pediatric Complete | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient Name (First, middle initial and last): DOB:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Specialty Consults** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IP Consult to Pediatric Hospitalist  IP Consult to Pediatric Intensivist | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IV** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Initiate IV protocol – Pediatric  Insert Peripheral IV | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | dextrose 5 % and sodium chloride 0.45 % ml/hr  dextrose 5 % and sodium chloride 0.45 % ml/hr | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | lactated ringers ml/hr  Other: ml/hr | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Antibiotics (Pre-Op)  No Antibiotics Indicated** | | | | | | | | | | | | | | | | | | | **Yes \*\*Order Antibiotics see ORDERS Addendum\*\*\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Pain Medications (Pre-Op)  N/A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Ropivacaine infusion ball 750 mL double lumen select a flow | | | | | | | | | | | | | | | | | | | | | | |  | | Less than 40 kg | | | | | | | | | | | | | | |  | Greater than 40 kg  **PROVIDER  INITIALS:** | | | | | | | |
| **Peripheral Nerve Block** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Bupivacaine-EPINEPHrine PR 0.23%-1:200,000 with Clonidine 50 mcg in 30.5 mL Once, Preoperative**  **PED ESP Block (up to 65 KG)**  ☐ EXPAREL 4mg/kg + bupivacaine 2mg/kg in 0.9% sodium chloride, infiltration only. **Total Volume:** ☐ 60mL ☐ 120 mL ☐ 200 mL  **PED ESP Block (>65 kg)**  ☐ EXPAREL 266 mg + bupivacaine 133 mg in 0.9% sodium chloride, infiltration only. **Total Volume:** ☐ 60mL ☐ 120 mL ☐ 200 mL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Intrathecal baclofen** | | | ☐ baclofen (GABLOFEN) 1,000 mcg/mL intrathecal solution 20mL, intrathecal | | | | | | | | | | | | | | | | | | | | | | | | | | ☐ baclofen (LIORSEAL) 2,000mL mcg/mL intrathecal solution 20 mL, intrathecal | | | | | | | | | | | | | | | | | | | | |
| **Anesthesia ❑ N/A** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Bier Block |  | | Epidural | | | | |  | | General | | | | | | |  | | Local with Conscious Sedation | | | | | | | | | | | | |  | | | | Local with no Sedation | | | | | | |  | MAC | | | | |
|  | Regional Block |  | | SAB | | | | |  | | TIVA | | | | | | |  | | TBD by Anesthesia | | | | | | | | | | | | |  | | | | N/A (No Anesthesia resource involved) | | | | | | | | | | | | |
| **Type of Optional Post-Op Analgesia ☐ N/A** Type of Optional Post-op analgesia requested to be completed by an Anesthesia provider. Anesthesia to perform block due to treatment technique beyond the experience of the operating physician.  **\*Indicate laterality if appliable** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Adductor Canal ☐ Right ☐ Left | | | |  | | Bier Block ☐ Right ☐ Left | | | | |  | | | | | Caudal | | | | | | | |  | | | Epidural | | | |  | | | Fascia Iliaca ☐ Right ☐ Left | | | | |  | | | Femoral | | | | |  | Interscalene ☐ Right ☐ Left |
|  | Interpectoral plane block ☐ Right  ☐ Left | | | |  | | Non specified Brachial Plexus Block ☐ Right ☐ Left | | | | | | | | | | | | | | | | | |  | | | Paravertebral ☐ Right ☐ Left | | | |  | | | Peripheral nerve Catheter ☐ Right ☐ Left | | | | | | | | | | | | |  | Popliteal ☐ Right ☐ Left |
|  | Saphenous ☐ Right ☐ Left | | | |  | | Sciatic ☐ Right ☐ Left | | | | |  | | | | | Spinal with Morphine | | | | | | | |  | | | Transverse Abdominis ☐ Right ☐ Left | | | | | | | | | | | |  | | | Rectus Sheath ☐ Right ☐ Left | | | | | | |
|  | Upper Extremity ☐ Right ☐ Left | | | |  | | Lower extremity ☐ Right ☐ Left | | | | | | ☐ | | | Pectoserratus plane block ☐ Right ☐ Left | | | | | | | | | | | | | | | | | | | | ☐ | | Supraclavicular ☐ Right ☐ Left | | | | | | | | | | | |
|  | Other:: ☐ Right ☐ Left | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*Is there a secondary block? ☐ N/A \*Indicate laterality if applicable** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | |  |  | | | | | | | |  | | |  | | | | | | | | |  | | |  | | | | | | | | |  |  | | | | | |  |  | | |
| ☐ | Adductor Canal ☐ Right ☐ Left | | | | | ☐ | Bier Block ☐ Right ☐ Left | | | | | | | | ☐ | | | Caudal | | | | | | | | | ☐ | | | Epidural | | | | | | | | | ☐ | Fascia Iliaca  ☐ Right ☐ Left | | | | | | ☐ | Lower extremity  ☐ Right ☐ Left | | |
| ☐ | Femoral | | | | | ☐ | Interscalene ☐ Right ☐ Left | | | | | | | | ☐ | | | Non specified Brachial Plexus Block  ☐ Right ☐ Left | | | | | | | | | ☐ | | | Paravertebral  ☐ Right ☐ Left | | | | | | | | | ☐ | Popliteal  ☐ Right ☐ Left | | | | | |  |  | | |
| ☐ | Saphenous ☐ Right ☐ Left | | | | | ☐ | Sciatic ☐ Right ☐ Left | | | | | | | | ☐ | | | Spinal with Morphine | | | | | | | | | ☐ | | | Transverse Abdominis ☐ Right ☐ Left | | | | | | | | | ☐ | Rectus Sheath  ☐ Right ☐ Left | | | | | |  |  | | |
| ☐ | Upper Extremity ☐ Right ☐ Left | | | | | ☐ | Pectoserratus plane block ☐ Right ☐ Left | | | | | | | | ☐ | | | Interpectoral plane  block ☐ Right ☐ Left | | | | | | | | | ☐ | | | Peripheral nerve Catheter  ☐ Right ☐ Left | | | | | | | | | ☐ | Supraclavicular ☐ Right ☐ Left | | | | | | | | | |
| **Additional Orders (any medication orders must include medication, dose, route and phase of care)  N/A**  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PROVIDER SIGNATURE: DATE: TIME:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |