PETERSON
REGIONAL MEDICAL CENTER

Pre-Admission Clinic and Admission Orders

Diagnosis/ Procedure	Diagnosis: ____ Procedure: ____ ICD10 code: ____
Status	SDC Inpatient /Admission **Attending MD:** ____
Consults	Pre-Op Clearance Request Form sent to Dr: ____ Hospitalist consult : Reason: ____
Med/Food Reactions	NKA **Allergies:** ____ **Adverse Reactions:** ____
Diet	NPO after the midnight before surgery except take Beta Blocker if you are already taking one: (____) at your usual time **(**Core Measure**)**
Diagnostics	**Pre-Admission** CBC Comp Bas Coag Bas w/o Gluc Type & Screen Type & Cross ___units UA Urine culture Chest Xray EKG 12 lead ____ **DOS** Coag Serum HCG or Urine HCG (for Unsterilized Females of Childbearing Age) ____ ____ **Screen patient for MRSA risk by CDC screening tool: All patients admitted to PRMC who screen positive will be tested for MRSA by PCR nasal swab or Culture. Culture if > 72 hours before admission or > 96 hours prior to Monday admission.**
DVT prophylaxis	SCDs **(**Core Measure**)** TED Hose (knee high) **(**Core Measure**)**
STOP	Drugs to STOP before surgery: stop ASPIRIN ____(date); stop PLAVIX ____(date); stop COUMADIN (warfarin) ____(date) OTHER DRUGS TO STOP: ____
IV at KVO On arrival	0.9% NS LR Other____
Other Orders	Peridex 30 ml PO swish/expectorate Incentive Spirometer Teaching

Physician Signature: ____ Date: ____ Time: ____

T.O.R.B ____ Date: ____ Time: ____

SPF 600-16

PETERSON
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Pre-Admission Clinic and Admission Orders

	Procedure	Antibiotics to Administer
Antibiotics	**Cesarean section**	□ Cefazolin *(administer 30 minutes before surgery)* • Patient less than 70 kg, give cefazolin 1gm IV x 1 dose • Patient 70 kg or more, give cefazolin 2 gm IV x 1 dose □ *Alternative Regimen (allergy)* • Clindamycin 600 mg IV x 1 dose **AND** • Gentamicin7 mg/kg IV based on adjusted body weight (To be dosed by Pharmacy)
	Hysterectomy	□ Cefazolin *(administer 30 minutes before surgery)* • Patient less than 70 kg, give cefazolin 1gm IV x 1 dose • Patient 70 kg to 120 kg, give cefazolin 2 gm IV x 1 dose • Patient greater than 120 kg, give cefazolin 3 gm IV x 1 dose □ *Alternative Regimen (allergy)* • Metronidazole 500 mg IV x 1 dose **AND** • Gentamicin7 mg/kg IV based on adjusted body weight (To be dosed by Pharmacy)
	Abdominal/ Colorectal Surgery	□ Cefazolin *(administer 30 minutes before surgery)* • Patient less than 70 kg, give cefazolin 1gm IV x 1 dose • Patient 70 kg to 120 kg, give cefazolin 2 gm IV x 1 dose • Patient greater than 120 kg, give cefazolin 3 gm IV x 1 dose □ *Alternative Regimen (allergy)* • Metronidazole 500 mg IV **AND** • Gentamicin7 mg/kg IV based on adjusted body weight (To be dosed by Pharmacy) Procedures requiring ANAEROBIC coverage (appendectomy, small bowel surgery with intestinal obstruction, colon procedures), **ADD:** □ Metronidazole 500 mg IV once *(administer 30 minutes before surgery)* If MRSA suspected, **ADD**: □ Vancomycin (begin administration 120 minutes before surgery) • Patient 51-70 kg, give vancomycin 1000mg IV x 1 dose • Patient 71-85 kg, give vancomycin 1250mg IV x 1 dose • Patient 86-100 kg, give vancomycin 1500 mg IV x 1 dose • Patient greater than 100 kg, give vancomycin 2 gm IV x 1 dose
	Genitourinary Procedures	□ Cefazolin *(administer 30 minutes before surgery)* • Patient less than 70 kg, give cefazolin 1gm IV x 1 dose • Patient 70 kg to 120 kg, give cefazolin 2 gm IV x 1 dose • Patient greater than 120 kg, give cefazolin 3 gm IV x 1 dose □ *Alternative Regimen (allergy)* • Levofloxacin 500 mg IV x 1 dose ***No prophylaxis recommended for clean urologic procedures in patients without risk factors for postoperative infections.

Physician Signature: ______________________________ Date: __________ Time: __________

T.O.R.B ______________________________ Date: __________ Time: __________

Patient Label

PRMC SURGERY/INVASIVE PROCEDURE HISTORY & PHYSICAL

H&Ps over 30 days cannot be used.

HISTORY

DATE:
Present Illness:
Allergies:
Medications:
Bleeding Tendency:
Past History:

PHYSICAL EXAMINATION

O=No abnormalities or changes

X=Abnormalities or changes from last physical examination (describe)

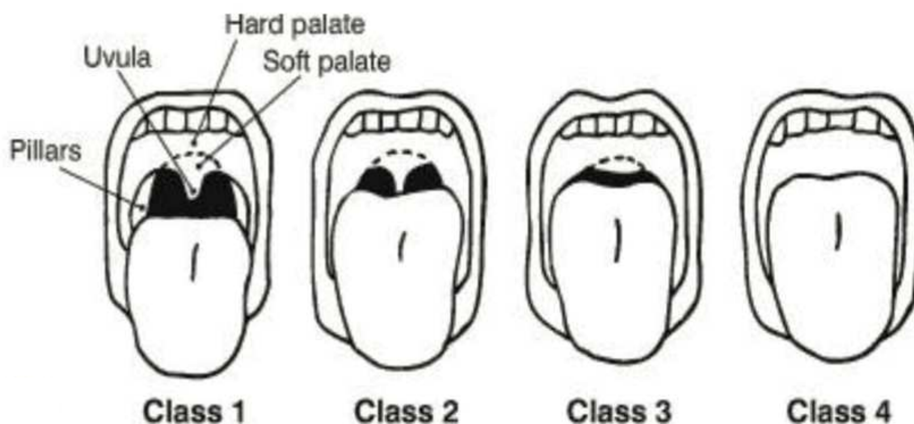
Eyes:
Ears:
Nose:
Head & Neck:
Mouth & Throat:
Breast:
Heart:
Lungs:
Abdomen:
Pelvis:
Rectal:
Extremities:
Neurologic:
COMMENTS:
Plan for Sedation-Anesthesia-Analgesia: ☐ Anesthesia Assist ☐ None ☐ PO ☐ Local ☐ Moderate Sedation
If Moderate Sedation Planned: ASA Class: ☐ ASA I ☐ ASA II ☐ ASA III ☐ ASA IV
Airway Assessment: ☐ MP 1 ☐ MP 2 ☐ MP 3 ☐ MP 4
Physician signature ***Date*** ***Time***
SPF 533-16

The American Society of Anesthesiologists
Physical Status Classification System

CONSIDER ANESTHESIA SUPPORT FOR ASA CLASS IV OR GREATER

	ASA I	ASA II	ASA III	ASA IV	ASA V
Walk up 2 flights of stairs or walk 2 city blocks.	"Healthy" ++	"Mild Systemic Disease" + (rest at completion)	"Severe disease but not incapacitating" 0 (rest before finishing)	"Incapacitating Disease" — (unable)	"Dying" — (unable)
Examples:	Healthy	Healthy pregnant female Older than 60 years Extremely phobic Drug allergy 140 - 159 Systolic 90 - 94 Diastolic Type II Diabetic Well-controlled epilepsy Well-controlled asthma Controlled hyper - or hypothyroid	Well controlled Type I diabetic Symptomatic thyroid disease MI more than 6 months prior with no residual effects Stroke more than 6 months prior with no residual effects 160 -169 Systolic 95 - 114 Diastolic Asthma stress or exercise induced or hospitalized Stable angina pectoris Heart failure with orthopnea and/or ankle edema COPD	Unstable angina MI less than 6 months prior Stroke less than 6 months prior 200 or higher Systolic 115 or higher Diastolic Uncontrolled cardiac arrhythmias Severe heart failure Severe COPD Uncontrolled epilepsy Uncontrolled diabetes	End stage disease
Treatment Modification:	None Needed (Green light)	Stress reduction protocols recommended where indicated (Yellow light)	Elective care appropriate; Stress reduction protocols recommended (Yellow light)	Non-invasive treatment only until patient's health improves and becomes Class III (if invasive treatment is required, refer to hospital) (Red light)	Palliative treatment (Red light)

****



The Mallampati Score:

Class 1. Complete Visualization of the soft palate
Class 2. Complete Visualization of the uvula
Class 3. Visualization of only the base of the uvula
Class 4. Soft palate not visible at all

CONSIDER ANESTHESIA SUPPORT FOR MALLAMPATI CLASS 3 & 4

PRMC DISCLOSURE AND CONSENT FOR MEDICAL, SURGICAL AND DIAGNOSTIC PROCEDURES

TO THE PATIENT: *You have the right, as a patient to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent for the procedure.*

I voluntarily request Dr.____as my physician, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition which has been explained to me as:____

____

I understand that the following surgical, medical and diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures:____

____

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I **(DO) pt_____witness_____ (DO NOT) pt____witness_____**consent to the use of blood and blood products as deemed necessary. I understand the risks and hazards associated with the use of blood and blood products are: fever, transfusion reaction which may include kidney failure or anemia, heart failure, hepatitis, AIDS (Acquired Immune Deficiency Syndrome) and other infections.

I understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions and even death. I also realize that the following risks and hazards may occur in connection with this particular procedure(s):

☐SEE ATTACHED PAGE FOR RISKS AND HAZARDS FOR LIST A OR LIST B PROCEDURES

OR

☐RISKS AS EXPLAINED TO ME BY MY PHYSICIAN____

____

I understand that anesthesia involves additional risks and hazards but I request the use of anesthetics for the relief and protection from pain during the planned and additional procedure. I realize the anesthesia may have to be changed possibly without explanation to me. I understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort to injury to vocal cords, teeth or eyes. I understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non treatment, the procedures to be used, and the risks and hazards involved, and believe that I have sufficient information to give this informed consent.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blanks spaces have been filled in and that I understand its contents.

DATE____________TIME______________ ____

PATIENT OR OTHER LEGALLY RESPONSIBLE PERSON SIGN (RELATIONSHIP)

__________________________	____________________	________________________
WITNESS (Print and signature)	WORK ADDRESS	CITY, STATE, ZIP CODE

PHYSICIAN CERTIFICATION

I hereby certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, the proposed procedure/operation. I have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/guardian understands what I have explained and has consented to undergo the proposed procedure/operation.

Physician signature____Date______________________Time________

 This form is designed to comply with the requirements promulgated by the Texas Medical Disclosure Panel

Pre-surgical Instructions

Date of Surgery: ___________________________ Surgery location: **Main Hospital**

Pre-Registration Instructions

Patient Registration will call you to pre-register for your surgery and the pre-admission clinic will call to schedule your pre-admission clinic appointment, if one is needed.

Please record your pre-admission clinic appointment date/time below:

______________________________________at _________________

If you need to change this appointment time for any reason or have any questions or concerns, please call the pre-admission nurses at 258-7106.

Pre-Admission Clinic Instructions

The pre-admission clinic is located in the Ambulatory Care Center at 260 Cully Drive. Please report to the pre-admission/lab area. You **do not** need to stop at the registration area unless instructed to do so by Registration when they call you.

You may eat and drink prior to your pre-admission clinic appointment.

Please take a list of all of your current medications including the name, dosage and time of day taken. Be sure to include any aspirin, vitamins, nutritional or herbal supplements that you have taken in the last 30 days.

Additional Surgeon Instructions

If you are taking any of the following medications, please discontinue their use on the date indicated by your surgeon:

(Medication Name - date to discontinue)

Aspirin ___________ Coumadin __________ Plavix ____________________

NSAIDS __________ Vitamin E___________ Other Vitamins ____________

Other Instructions: ____

____

PRMC Pre-Admission Clinic is located in the Ambulatory Care Center

260 Cully Dr. Kerrville, TX 78028

Phone: 258-7106 Fax: 258-7595

SPF 331-14b

Day of Surgery Instructions

Peterson Regional Medical Center
551 Hill Country Dr.   Kerrville, TX

Date_________________   Arrival Time_________________

Enter the hospital, turn right and take the elevators to the 2nd floor. Upon exiting the elevator, turn right and go through the double doors. Follow the signs to the surgery waiting area on the right side of the hallway. You will be greeted by registration in the surgery waiting area.

☐ **DO NOT EAT OR DRINK ANYTHING AFTER MIDNIGHT THE NIGHT BEFORE YOUR SURGERY.**

Failure to follow these instructions can result in cancellation of your surgery

Please take the following medications with a small sip of water on the morning of your surgery:

____

____

Do not shave your surgical area ● Do not wear make-up or jewelry ● Wear loose-fitting clothing and low-heeled comfortable shoes.

Bathe or shower with anti-bacterial soap before coming to the hospital

Wash hair within 24 hours of surgery

If you are going home after your surgery, you MUST have someone that can drive you home and get you settled.

It is against hospital policy for patients to use taxis or public transportation after surgery unless you are accompanied by the person that is going to get you settled at home.

PRMC Pre-Admission Clinic is located in the Ambulatory Care Center
260 Cully Dr.   Kerrville, TX 78028
Phone: 258-7106   Fax: 258-7595

Peterson Regional Medical Center
SURGICAL PRE-ADMISSION CONSULT

SURGEON INSTRUCTIONS:

1. Complete this section
2. Fax this form to ____________________ (primary care physician or cardiologist you have consulted)
   OR
   If consulting the Sound Hospitalist group fax to the pre-admission clinic: 258-7595

Patient Name: ___________________________________ Date of Birth: ___________________________

Diagnosis: ______________________________________ Surgical Procedure: ______________________

Surgical Plan: ____ outpatient ____ admission Date Scheduled: _________________________

<u>Patient needs medical evaluation for the following condition(s)</u>:

[ ] CAD [ ] CHF [ ] Valvular heart disease [ ] Pacemaker [ ] PVD [ ] HTN [ ] Diabetes

[ ] COPD [ ] Sleep apnea [ ] Pulmonary HTN [ ] Renal insufficiency/failure [ ] Bleeding disorder

[ ] Other ____

Surgeon's Name: ___________________________________ Surgeon's Fax: ________________________

Signature: ____ Date: __________________________

CONSULTANT INSTRUCTIONS:

1. Complete this section and attach recent pertinent test done outside of PRMC.
2. Fax to the surgeon's office and the pre-op clinic (see above).

[ ] CAD: revascularization procedures ____
Current ischemia risk: [ ] very low [ ] low [ ] moderate [ ] high

[ ] CHF or cardiomyopathy or impaired LV function: most recent EF: __________ %

[ ] Aortic stenosis: Valve area: __________cm^2 Gradient: __________mmHg

[ ] Pulmonary hypertension: pulmonary artery pressure __________ etiology: _____________________

[ ] Pacemaker [ ] AICD (please attach copy of patient ID card)

Other: ____

____

[ ] The patient has been evaluated and no further pre-operative testing is recommended at this time.

[ ] The patient is NOT medically stable for the planned surgical procedure at this time.

Consultant's Name: ___________________________________ Phone number: ____________________