



One Medical Center Drive
 P.O. Box 626
 Biddeford, ME 04005-0626
 (207) 283-7000

Pre-Operative Orders GU/ESWL

Diagnosis <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Renal <input type="checkbox"/> Ureteral <input type="checkbox"/> Stone	Allergies
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|-------------------------------------|--|---|--|
| <input type="checkbox"/> CBC | <input type="checkbox"/> Chem Profile | <input type="checkbox"/> CEA | <input type="checkbox"/> T/S |
| <input type="checkbox"/> EKG | <input type="checkbox"/> CXR | <input type="checkbox"/> Coag Panel | <input type="checkbox"/> T/C - #____units |
| <input type="checkbox"/> LYLES | <input type="checkbox"/> U/A | <input type="checkbox"/> Incentive Spirometer | <input type="checkbox"/> Autologous Blood #____units |
| <input type="checkbox"/> BUN | <input type="checkbox"/> U/A – C&S | | <input type="checkbox"/> Pulse Ox |
| <input type="checkbox"/> Creatinine | <input type="checkbox"/> HCG ____urine ____serum | | <input type="checkbox"/> ABG |

Day Of Surgery – Fingerstick CBC Coag Panel EKG Other: _____
 HCG - urine (if cannot void, do serum)

KUB: <input type="checkbox"/> KUB Morning of Procedure <input type="checkbox"/> Print films to accompany patient to OR for ESWL <input type="checkbox"/> No AM KUB, recent films adequate <input type="checkbox"/> Do not print films – Physician will review x-rays on IMPAX <input type="checkbox"/> Recent films to accompany patient to OR for ESWL
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Other: _____

DVT Prophylaxis: Heparin 5000 units SC given in Holding Area
 SCDs applied in OR TEDs ____thigh ____knee

Procedure	Recommended Antibiotic
Routine Urology Or ESWL	<input type="checkbox"/> Cefazolin – 1 gram IV or <input type="checkbox"/> _____ Low Risk Penicillin allergy: <input type="checkbox"/> Allergy noted – OK to give Cefazolin High Risk Penicillin allergy: <input type="checkbox"/> Ciprofloxacin 400mg IV
Penile Prosthesis Insertion/Removal/ Revision	<input type="checkbox"/> Cefazolin – 1 gram IV and Gentamicin 1.5mg/kg X____kgs=____mgs IV or <input type="checkbox"/> Piperacillin/Tazobactam 3.375g IV Low Risk Penicillin allergy: <input type="checkbox"/> Allergy noted – OK to give Cefazolin High Risk Penicillin allergy: <input type="checkbox"/> Vancomycin 1g IV and Gentamicin 1.5mg/kg X____kgs=____mgs IV
Transrectal Prostate Biopsy	<input type="checkbox"/> Cefazolin – 1 gram IV or <input type="checkbox"/> _____ Low Risk Penicillin allergy: <input type="checkbox"/> Allergy noted – OK to give Cefazolin High Risk Penicillin allergy: <input type="checkbox"/> Metronidazole 500mg IV and Gentamicin 1.5mg/kg X____kgs=____mgs IV

Physician Signature _____ Date: _____ Time: _____