A THERAPEUTICALLY EQUIVALENT PRODUCT MAY BE DISPENSED AND ADMINISTERED UNLESS CHECKED IN THE LEFT COLUMN.

| ✓ | LIVER SURGERY PRE-OPERATIVE | ROOM NO. |
|---|---|---|

**ALLERGIES (list reactions):** HT _____ (Cm) WT _____ (Kg)

**A ☑ indicates a selected order. If a defaulted order is not appropriate, draw a line through the order.**

**Surgery Consent/Procedure: (✓ all that apply)**

☐ Radiofrequency Ablation (RFA) of Liver ☐ Resection of Liver
☐ Intraoperative Ultrasound (IOUS) ☐ Diagnostic Laparoscopy ☐ Cholecystectomy
☐ Hepatic Artery Infusion (HAI) Pump Placement
☐ Other _____
☐ Biopsy of _____

☐ Pre-surgical testing not completed at St. Joseph Hospital; all pre-surgical results to be faxed to SJO pre-op department (714) 368-8362 within 72 hours prior to surgery date.

**Diagnosis:** _____
☑ Surgeon: _____
☑ Surgery Date _____

**Isolation (check all that apply):**

☐ Airborne precautions ☐ Contact precautions ☐ Droplet precautions
Reason for isolation: _____

**Nursing:**

☑ Provide pre-procedural education
☑ Have patient void on-call to procedure
☑ If patient is diabetic, check capillary blood glucose upon arrival to Pre-Op Department
☐ Hair removal with electric clippers immediately prior to surgery
☐ Other _____

**Nutrition:**

☑ NPO ☐ after midnight ☐ 6 hours pre-procedure ☐ except PO meds

**LAB:**

☐ Pre-procedural labs within 30 days before surgery: ☐ BMP ☐ CMP ☐ CBC ☐ aPTT ☐ PT ☐ UA
☐ Quantitative Serum Pregnancy (HCGB) within 7 days of surgery counting the day blood was drawn
☐ Other _____

**12-hour Chart Check** _____ **RN DATE:** _____ / _____ / _____ **TIME:** _____

**T.O.** _____ **Taken by:** _____ ____/____/____, **TIME:** _____

**TRANSCRIBED BY:** _____ ____/____/____, **TIME:** _____ **NOTED BY:** _____ ____/____/____, **TIME:** _____

**PHYSICIAN SIGNATURE:** _____ **DATE:** _____ **TIME:** _____

**PRINTED NAME/ID#:**

(COUNTER-SIGN ALL T.O. ORDERS WITHIN 48 HOURS, AND INCLUDE THE DATE/TIME AUTHENTICATED)

St. Joseph Hospital
ST. JOSEPH HEALTH SYSTEM

**LIVER SURGERY PRE-OPERATIVE**
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PATIENT ID

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| ✓ | LIVER SURGERY PRE-OPERATIVE | ROOM NO. |
|---|---|---|

**ALLERGIES (list reactions):** HT _____ (Cm) WT _____ (Kg)

**Blood Bank:**
Date Needed: _____ Time Needed: _____
Surgery Date: _____ Surgery Time: _____
☐ Type and Screen
☐ Red Blood Cells (RBC) _____units
☐ Autologous ☐ Directed ☐ Irradiated ☐ CMV Negative ☐ Washed
☐ Platelets (PHPLT) _____units
☐ Directed ☐ Irradiated ☐ CMV Negative
☐ Thawed Plasma (TPL)_____units

**Procedures:**
☑ 12-lead EKG within 30 days before the day of surgery. Reason for exam: preoperative
☐ CXR (2 View) within 60 days before the day of surgery. Reason for exam: preoperative
☐ Other _____

**IV Fluids:**
☑ IV _____to run at _____ mL / hour

**Medications:**
Antibiotics:
☐ Cefoxitin ____Gm IVPB within 60 minutes prior to incision (given by Anesthesiologist) X 1
☐ Vancomycin ____ Gm IVPB X 1. Administer within 120 minutes prior to incision preoperatively. (Infuse over 60 minutes.)

**Additional Orders:**

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

**12-hour Chart Check**_____ **RN DATE:** _____ / _____ / _____ **TIME:**_____

**T.O.** _____ **Taken by:** _____ ____/____/____, **TIME:**_____

**TRANSCRIBED BY:** _____ ____/____/____, **TIME:** _____ **NOTED BY:**_____ ____/____/____, **TIME:**_____

**PHYSICIAN SIGNATURE:** _____ **DATE:** _____ **TIME:** _____

**PRINTED NAME/ID#:** (COUNTER-SIGN ALL T.O. ORDERS WITHIN 48 HOURS, AND INCLUDE THE DATE/TIME AUTHENTICATED)

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**LIVER SURGERY PRE-OPERATIVE**
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