Boarding Fax 810-667-5658
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McLaren Lapeer Region
LAPEER, MI 48446

PRE-ADMISSION / PRE-PROCEDURE INFORMATION

Name of Patient:	Admitting Diagnosis:	
Physician:		
Procedure:	Date of Admission:	Date of Procedure:
	Height:________ inches _________ cm	Weight:______lbs ______kg
Pre-authorization/Procedure Number:	Smoker: ☐ Yes ☐ No · Birthdate:________________	Sex: ☐ Male ☐ Female
Authorization number given by:	Date Authorization number given:	

PRE-ADMISSION/PROCEDURE NOTE:

Specify any **ALLERGIES the patient may have (including Anesthetic):

PROCEDURE VERIFIED ON “IN PATIENT ONLY LIST”:____________Initial

☐ In pt ☐ Out pt ☐ Pre-surgical testing required ☐ Admit Post Op ☐ Admit prior to surgery date

PHYSICIAN ORDERS

LABORATORY
- ☐ CBC
- ☐ UA
- ☐ UCG
- ☐ HCG (QUAL)
- ☐ Electrolytes
- ☐ Glucose
- ☐ Acid Phos.
- ☐ Creatinine
- ☐ BUN
- ☐ VDRL
- ☐ Auto Donor
- ☐ Blood Type& Cross
- ☐ Blood Type & screen
- ☐ RH Factor
- ☐ CMP (Includes Lytes)
- ☐ Nasal swab for MRSA
- ☐ Per Anesthesia protocol
- ☐ PTT
- ☐ PT

Dx:
- ☐ Anticoagulant Therapy
- ☐ Liver Disease
- ☐ Hemorrhage
- ☐ Anemia
- ☐ ____________

DIAGNOSTIC IMAGING
- ☐ PA & lat chest
  Reason:

CARDIOPULMONARY
- ☐ EKG
- ☐ Spiro Care Teach

PHYSICAL THERAPY
- ☐ Tens unit teach
- ☐ Crutch Walking

Please choose appropriate pre-op antibiotic based on surgical procedure/SCIP guidelines.

- ☐ **Cefazolin** (Kefzol)1gm IVPB x 1 (pts < 80kg)
- ☐ **Cefazolin** (Kefzol) 2gm IVPB x 1 (pts 80kg or more)
- ☐ **Clindamycin** 600mg IVPB x 1 (pts < 80kg)
- ☐ **Clindamycin** 900mg IVPB x 1 (pts 80kg or more)

- ☐ **Cefoxitin** (Mefoxin) 1gm IVPB x 1 (pts < 80kg)
- ☐ **Cefoxitin** (Mefoxin) 2gm IVPB x 1 (pts 80kg or more)
- ☐ **Ciprofloxacin** 400mg IVPB + Metronidazole (Flagyl) 500mg IVPB x1
- ☐ **Gentamicin** 1.5mg/kg IVPB x 1
- ☐ **Ciprofloxacin** 400mg IVPB x 1
- ☐ Other: ____
- ☐ Other: ____
- ☐ Other: ____

**For Orthopedic surgeries, Pharmacy is to send both pre-op dose and PACU dose of Cefazolin or Clindamycin.

FOR KNEE/HIP SURGERIES:
- ☐ **Tranexamic Acid** 1 gm IVPB x 1 dose- give 1gm IVPB at initiation of wound closure
- ☐ **Bacitracin** 100,000 units in 3000ml NaCl 0.9% for Irrigation to be used in OR

*** **VANCOMYCIN** (MUST document reason for use) ***
- ☐ **Vancomycin** 1gm IVPB x 1 (pts <80kg)
- ☐ **Vancomycin** 1.5gm IVPB x 1 (pts 80kg or more)

***** VANCOMYCIN REASONS FOR USE *****
- ___ **Beta lactam allergy (SEVERE)**
- ___ **MRSA colonization/infection**
- ___ **Hosp/nursing home/ECF w/in past yr**
- ___ **Increased MRSA infection w/in hospital**
- ___ **Chronic wound care/dialysis**
- ___ **Prolonged hospital stay/recent abx use**
- ___ **HIV infection/IV drug abuse**
- ___ **Purulent drainage/abscess**
- ___ **Other (specify reason): ____________**

***** Vancomycin should only be used for one of the reasons listed above OR in patients undergoing procedures with an implantable device *****

Is a Consult necessary: ☐ Yes ☐ No
If Yes, has it been performed: ☐ Yes ☐ No
Consultant:____________________ * **Attach Consult Report

POST PROCEDURE STATUS:
- ☐ Discharge Home
- ☐ Admit (Post-op care expected to go beyond 24 hrs)
- ☐ OBS (Post-op care expected to last greater than 24 hours)

☐ *TO* ☐ *VO* ☐ *TO/VO Read back and verified* *Physician Name:*	*Nurse Signature:*	*Date:*	*Time:*
	Physician Signature:		

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