



ORDERED		ORTHOPAEDIC OPS ORDERS	TIME
DATE	TIME		ORDER NOTED
		Inpatient Admit to Dr. _____ on _____ (Date).	
		Diagnosis:	
		Operative Permit for:	
		Obtain Blood Permit signature:	
		Start IV Lactated Ringers at 30 ml/hour	
		Ortho Prep in OR	
		Ancillary: <input type="checkbox"/> CBC with Diff <input type="checkbox"/> CBC <input type="checkbox"/> UA <input type="checkbox"/> Sed Rate <input type="checkbox"/> CMP <input type="checkbox"/> PT/PTT <input type="checkbox"/> CXR (2 view), <input type="checkbox"/> EKG <input type="checkbox"/> ABG's <input type="checkbox"/> Type and Screen <input type="checkbox"/> Type and Cross _____ Units.	
		Other:	
		Preop Antibiotic:	
		<input type="checkbox"/> Cefazolin (Ancef) 1 gm IV in OR (weighs < 80 kg)	
		<input type="checkbox"/> Cefazolin (Ancef) 2 gm IV in OR (weighs > 80 kg)	
		Allergy to Beta Lactam:	
		<input type="checkbox"/> Clindamycin 600 mg IV in OR within 1 hour of incision.	
		<input type="checkbox"/> Vancomycin 1 gram IV in OR within 2 hours of incision.	
		If Vancomycin infusion expected to exceed the 2 hour window prior to incision, notify the physician for a Clindamycin order.	
		<input type="checkbox"/> Vancomycin (other indication for use) 1 gram IV in OR within 2 hours of incision	
		If Vancomycin infusion expected to exceed the 2 hour window prior to incision, notify the physician for a Clindamycin order.	
		<input type="checkbox"/> Known Beta Lactam allergy	
		<input type="checkbox"/> Known prior colonization with MRSA	
		<input type="checkbox"/> High risk due to acute inpatient hospitalization within last year	
		<input type="checkbox"/> High risk due to nursing home or extended care facility within past year	
		<input type="checkbox"/> Increased MRSA rate, either facility-wide or operation-specific	
		<input type="checkbox"/> Chronic wound care or dialysis	
		<input type="checkbox"/> Continuous inpatient stay, more than 24 hours prior to the principal diagnosis	
		<input type="checkbox"/> Other reason:	
		Beta Blocker:	
		If > 24 hours since last dose, prior to anticipated surgery time, give _____ with sips of water.	
		Hold beta blocker for pulse < 50 and/or systolic BP < 100.	
		Physician Signature: _____ Date/Time: _____	



**PHYSICIAN'S ORDERS
ORTHOPAEDIC OPS ORDERS**

▼ Patient Label ▼