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Revised 11/06

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**PHYSICIAN’S ORDERS**

Standard Post–Operative Orders for Inpatient or Outpatient Patients
**SCIP Compliant**

1. To PACU, then transfer to: __________________________________________________________

2. Resuscitation status:  
   - [ ] Full resuscitation  
   - [ ] Other ______________________

3. Activity: _____________________________________________________________

4. Diet: _________________________________________________________________

5. IV fluids: _________________________________  
   - [ ] Heplock

6. Consults/Courtesy Notifications: ________________________________________________

7. Diagnostics: 
   a. Labs: ______________________________________________________________
   b. Radiology: __________________________________________________________
   c. Other: _____________________________________________________________

8. Treatments 
   a. Nursing Orders
      - Vital Signs: ______________________________________________________
      - Other: __________________________________________________________
   b. Respiratory: _________________________________________________________
   c. Foley: _____________________________________________________________
   d. Other drain (s) /dressings: ____________________________________________
   e. Physical Therapy: ____________________________________________________
   f. DME−like requirements (soft collar, pillows, etc.): _________________________
   g. SCDs: To remain on the patient if applied intraoperatively.

9. Medications: 
   a. Pain Medications: ______________________________________________________
   b. Nausea Medications: ____________________________________________________
   c. Comfort Medications: _________________________________________________
   d. Other: ______________________________________________________________
### PHYSICIAN’S ORDERS

#### Standard Post–Operative Orders for Inpatient or Outpatient Patients

**SCIP Compliant**

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10. **Antibiotic:**  
   - **Prophylactic**  
     - Treatment for:  
       - Current Infection
       - Current Possible or Suspected Infection
       - None

   - Post op antibiotic doses are **NOT** required, but if continued postop must discontinue prophylactic antibiotic within 24 hours of incision closure. (48 hours for CABG and other Cardiac surgeries)

   - cephalazin (ANCEF) 1g IV Q 8 H x 2 doses postop if prophylactic
   - vancomycin 1g IV Q 12 H × 1 dose postop if prophylactic
   - cefoxitin (MEFOXIN) 1 g IV Q 6 H x 3 doses postop if prophylactic
   - metronidazole (FLAGYL) 500 mg IV Q 6 H x 3 doses postop if prophylactic
   - Other

   **PACU RN to complete PACU RN initials:**
   Incision closure time: Date: __________ Time: __________
   Next dose due Date: __________ Time: __________
   - 1st Dose
   - 2nd Dose

11. **VTE Prophylaxis:** Patient should receive the first dose within 24 hours of surgery.

   - Give first dose in PACU
   - Give first dose POD 1 within 24 H incision closure time

   - enoxaparin (LOVENOX) 40 mg SUBQ daily
   - heparin 5000 units SUBQ every 8 H
   - Contraindications for drug therapy–Must check a reason for contraindication
     - Patient must have SCDs or a documented contraindication to SCDs if no drug therapy.
     - Risk of bleeding
     - Active major, significant bleeding (e.g., cerebral hemorrhage)
     - Extreme thrombocytopenia (less than 50,000 mm³)
     - History of heparin–induced thrombocytopenia (HIT), contraindicated for use of heparins
     - Other conditions that could increase the risk of bleeding

   - Document Condition:

   - Excluded Populations for drug therapy–Must check a reason for exclusion
     - Patients less than 18 years of age
     - Patients who are on warfarin prior to admission
     - Patients with reasons for not administering Both mechanical and pharmacological prophylaxis. **MUST BE DOCUMENTED IN THE MEDICAL RECORD**

12. **Post–op Beta Blocker Therapy**

   - Not applicable
   - Continue beta blocker per medication reconciliation order

   - Beta blocker order:
     - Drug:
     - Consult Dr. ____________________________ or Hospitalist to order beta blocker.
     - Will address beta blocker dosing on POD#1 based on hemodynamic status.

     - If beta blocker not administered on POD#1 or POD#2, contraindication must be documented.

   **PACU RN to complete PACU RN initials:**

   - Was patient on home beta blocker therapy prior to arrival: Yes No
   - If yes, did the patient receive a beta blocker TODAY? Yes No

   **RN / PA Signature**

   **Date**

   **Time**

   **Physician Signature**

   **Date**

   **Time**
Request and Permission for Operation/Procedure

1. I ask and allow Dr. ____________________________ and/or associates or assistants of his/her choice to perform at Providence Hospital on:

   ________________________________________________________________

   (Type or Print) Name of Patient

   the following operation/procedure:  □ Left  □ Right  □ N/A

   Check Which Apply

2. Dr. ____________________________ has explained to me the operation/procedure, how it will help me, and the risks and possible discomfort that I may feel. The doctor has also discussed other choices for the proposed operation/procedure and the risks and consequences of no treatment. I understand that there is no guarantee of the outcome/result of the operation/procedure.

3. I understand that during the operation/procedure, unplanned medical conditions may come up which would require procedures different from the ones that are planned. I agree to allow those procedures to be done which the doctor or his/her associates or assistants may recommend.

4. I understand and consent to any testing necessary to proceed with my surgery, including testing for reportable diseases such as, but not limited to, Hepatitis, HIV, etc. These tests may be required by the surgeon and/or the anesthesia personnel. Pre-operative testing may include a urine pregnancy test. For females of childbearing age, Providence Hospital requires mandatory pregnancy testing prior to any surgery that involves the female reproductive system.

   □ I do not consent to pregnancy testing. If I am pregnant, I acknowledge and understand surgery has been associated with a higher than expected likelihood of spontaneous miscarriage. I have had an opportunity to ask questions and they have been answered to my satisfaction.

5. I agree to be given anesthetics/sedation as may be recommended by or under the direction of:

   □ Anesthesia

   □

6. To increase medical knowledge and education, I agree to videotaping, photographing, and/or televising the operation/procedure to be performed, provided my/the patient’s identity is not revealed. I also agree to allow health care personnel/student observers into the operating or procedure room.

7. If it is necessary, I agree to be given blood and/or blood products by transfusion. Known risks of transfusion include infections such as HIV (AIDS), hepatitis and immunological reactions. If I have requested autologous or directed donor blood and sufficient blood is not available, I may receive random donor blood. Other risks, benefits and alternatives for blood transfusion have been explained to me.

8. Any organs or tissues removed during the operation/procedure can be examined and kept by Providence Hospital for necessary medical, scientific, or educational purposes. I agree to let Providence Hospital dispose of these organs, or severed parts according to hospital rules.

9. I was given a chance to ask questions, and am satisfied with the answers that I was given. I have crossed out and initialed any part of this form, which does not relate to me. I understand that all information about my care will be kept confidential.

   (Continued)
10. I understand that I can change my mind and take back my permission at any time before the operation/procedure.

Patient/Relative/Guardian: ____________________________

(circle one)

______________________________
SIGNATURE | DATE | TIME

______________________________
Print Name

Relationship, if signed by person other than patient: ____________________________

Interpreter, if required:

______________________________
SIGNATURE | DATE | TIME

______________________________
Print Name

Witness: ____________________________

______________________________
SIGNATURE | DATE | TIME | PRINT NAME

Witness: ____________________________

______________________________
SIGNATURE | DATE | TIME | PRINT NAME

If not previously documented in medical record:

I have explained the nature, purpose, benefits, risks and alternatives to the proposed operation/procedure, expected results and possible results of nontreatment, have offered to answer any questions and have answered such questions. The patient/relative/guardian acknowledges an understanding of what I have explained and answered, and has consented to undergo the proposed operation/procedure.

Physician: ____________________________, M.D. ____________________________

Signature
Print Name

Date | Time: ____________________________

NOTE: THIS DOCUMENTATION WILL BE MADE PART OF THE PATIENT’S MEDICAL RECORD.
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**POST-OP / POST-PROCEDURE NOTES**

1. Pre-Operative Diagnosis:

2. Post-Operative Diagnosis:

3. Procedure:

4. Physician / Surgeon:

5. Anesthesia:

6. EBL:

7. Specimen:

8. Complications:

9. Condition:

10. Findings: ☐ Same as post-operative diagnosis

**CONDITION / PROGNOSIS ON DISCHARGE:**

---

Rev: 3/11

Physician Signature

Date Printed:

Date Time

PACU0002
**BLOCK TREATMENT RECORD**

**Date:** ______________  |  **Pre–Op Start:** ______________  |  **End:** ______________  
**OR Room #:** ______________  |  **OR Start:** ______________  |  **End:** ______________  
**Surgeon:** ______________  |  **MD Start:** ______________  |  **End:** ______________  
**Circulator:** ______________  |  **PACU Time:** ______________  
**Scrub:** ______________  |  **Pre–Op Diagnosis:** ______________  
**XRay:** ______________  |  **Surgical Procedure:** ______________  

---

**Medication Injection Charges**

- 35516689 – Initial IV Med infusion: ______________  |  **Start Time:** ______________  |  **Stop Time:** ______________  
- 35504168 – IV Push Additional Same Drug: ______________  |  **Pre–Op – L12**  
- 35516670 – IM or Sub Q Injection: ______________  
- 35516662 – IV Push Injection: ______________  |  **35504141 – IV Push Additional New Drug: ______________**  

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**Outpatient Surgery Implant & Equipment Verification Checklist / Logging / QA**

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<th><strong>Time Out:</strong> ______________</th>
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<td><strong>Case Set Up:</strong> ______________</td>
<td><strong>Finish:</strong> ______________</td>
<td><strong>Room Clean Up:</strong> ______________</td>
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| **Surgeon Late:** ______________  |  **(LO2)**  
| **Case Scheduled for:** ______________  |  **Surgery arrived at:** ______________  |
| **Case Bumped/Delayed until:** ______________  |  **Called Charge Nurse to Notify:** ______________  |  **Yes / No**  
| **Case Moved to Main OR:** ______________  |  **Case Cancelled:** ______________  |

**Case Delay**

- **Lab–L08**  
- **Anesthesia – L03**  
- **Pt. Late Arrival – L01**  
- **Pre–Op – L12**  
- **Transport – L13**  
- **Line Placement**  
- **Previous Case Ran Late – L07**  
- **Unavailable Equipment – C15**  
- **X–Ray – C–Arm – L09**  
- **X–Ray – Portable – L09**  
- **Unavailable Instruments**  
- **Unavailable Staff**  
- **Circulator – C19**  
- **Scrub – C18**  
- **Retractor – C17**  

**Length of Delay:** ______________  
**Comments:** ______________

**Difficult Intubation:**

- **(Q29)**  
- **Multiple Attempts**  
- **Flexible Intubation**  
- **Oral – Laryngeal Trauma**  
- **Light Wand**  
- **Laryngospasm**  
- **Case Cancelled**  

**Comments:** ______________

**Equipment Malfunction:**

- **(C09)**  
- **Removed from Patient Care**  
- **Report of Event Filed**  
- **Reported to Bio–Med for Repairs**  
- **Name of Equipment:** ______________  

**Case Cancelled Due to:**

- **Patient Condition – C03**  
- **Anesthesia – C02**  
- **Surgeon – C04**  
- **Patient Request**  
- **Case Transferred to Main OR – C24**  

**Comments:** ______________

**Patient Return to OR:**

- **(C23)**  
- **Hemorrhage**  
- **Airway Control**  
- **Unstable Vital Signs**  

**Comments:** ______________

---

**IF CASE CANCELLED WHILE PATIENT ON O.R. TABLE OR IF PATIENT RETURNS TO O.R. IN SAME DAY, YOU MUST FILL OUT REPORT OF EVENT FORM**

**IMPLANT INFORMATION: APPLY STICKERS IF AVAILABLE**

- **Manufacturer:** ______________  
- **Model #:** ______________  
- **Lot #:** ______________  
- **Size:** ______________  
- **Catalog #:** ______________  
- **Quantity:** ______________  
- **UCG:** [ ] Yes [ ] No
Outpatient Discharge Instructions from:
- Cardiology / (Cath & EP Lab)
- Emergency Room
- GI Lab
- Radiology
- Short Stay / Bronch Lab
- Surgery
- Day Surgery

I will be receiving sedation / anesthesia for my procedure. These instructions were explained to me before I received sedation.

1. You should not drive, operate machinery, make critical decisions, sign legal documents, or consume alcoholic beverages for 24 hours.
2. You should have a responsible adult stay with you for 24 hours.
3. You should understand instructions on any blood thinning medications.

I understand these instructions and will receive a copy on discharge.

Patient Signature Date Time

In the next 24 hours:

1. MY PROCEDURE: See attached information.

2. ACTIVITY:
   - See specific anesthesia instructions
   - As tolerated
   - Limited for _______ hours/days
   - Other: ____________________________

3. DIET:
   - See specific anesthesia instructions
   - As tolerated
   - Liquids, progress as tolerated
   - Clear liquids
   - Other: ______________________________

4. MEDICATIONS:
   - No changes recommended to your current medications.
   - See attached list for information on your medications (Take this list to your next doctor’s appointment).

5. EMERGENCY CONTACT:
   - If you experience any symptom that you are concerned is life threatening:
     - Call 911 for an ambulance
     - Or go to the closest Emergency Department.

6. OTHER INSTRUCTIONS:
   - 

Follow-up Care:

- Call physician’s office for appointment
- Follow-up appointment(s)
  - Date: _______ Time: _______ Doctor: _____________ Location: ________________________________
  - Date: _______ Time: _______ Doctor: _____________ Location: ________________________________
  - Other referrals: ________________________________________ N/A

Anesthesia or Sedation:

You/your family member have received:
- None received
- Light/moderate/heavy sedation
- Local anesthesia
- Spinal anesthesia
- General anesthesia

If you (your family member) have received ANY anesthesia or sedation, the following behaviors are not unusual for the first 24 hours:
- Groggy, dizzy, or less alert for the next few hours, but arousable.
- An infant or toddler may have difficulty holding his/her head up.
- Irritable or hyperactive when awake.
- Nausea with or without vomiting; vomiting may occur 1–2 times.
Anesthesia or Sedation (continued):

If you (your family member) have received ANY anesthesia or sedation, follow these guidelines for the next 24 hours:

**ACTIVITY:**
- There must be a responsible adult present for 24 hours.
- Do NOT allow your family member to walk/crawl alone until the sedation has completely worn off.
- Do NOT allow your family member to participate in activities that require good coordination or concentration.
- Do NOT allow your family member to drive any type of vehicle.
- Do NOT allow your family member to operate machinery.
- Do NOT allow your family member to make critical decisions or sign legal documents.
- Limit your family member’s activity. Allow your family member to resume full physical activity when his/her doctor gives you permission.
  - *Special considerations for Spinal anesthesia* – your family member should remain in bed or a recliner for 6–8 hours. They should only use the bathroom with assistance. Call physician for persistent severe headache or if unable to urinate 6–8 hours after arriving home.

**DIET:**
- Do NOT feed your family member until he/she is fully awake.
- Start with clear liquids (water, apple juice, 7–Up) and advance to their regular diet as tolerated.
- Do NOT allow your family member to drink alcoholic beverages for 24 hours.
- Nursing infants may have breast milk once awake.
  - *Special considerations for General anesthesia* – your family member may have a sore throat.

  - Use throat lozenges, warm liquids, and pain relievers as prescribed.

**MEDICATIONS:**
- Continue your current medications as instructed by the physician today.
- Be sure you understand the instructions on any blood thinning medication.
- Only take pain medications or sedatives as instructed by your physician today.
- Do NOT give your family member any medication that contains alcohol (example: cough syrup) for the next six (6) hours.

**SLEEPING:**
- Check your family member frequently during the ride home and throughout the day to assure he/she is able to breathe easily and has not vomited.
- At home, place your family member on his/her side during sleep.
- Your family member may not sleep well the first night after sedation, especially if he/she slept more than usual throughout the day.
- When using an infant carrier/seat, observe infants closely. If your infant falls asleep in the car, do not allow his/her head to fall forward or to the side. This position may block their airway and not allow them to breathe properly.

**WATCH FOR:**
- Frequent vomiting
- Difficulty breathing
- Skin very pale or grayish in color
- Unable to awaken from sleep

If any of these occur, call 911 or go to the nearest Emergency Department.

The instructions above were explained to me. I understand these instructions and am the responsible adult caring for this patient.

Signature of Responsible Adult ___________________________ Date __________ Time __________

Signature of Discharge Nurse ___________________________ Date __________ Time __________

If you receive a survey about the service you experienced during this visit with us, please give us your opinion of our performance. We desire to make each visit an excellent visit. Your response assists us with continuous improvement. Thank you in advance for completing the survey.