HARTFORD HOSPITAL
80 Seymour St. P.O. Box 5037
Hartford, CT 06102-5037

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Check box to initiate order

549328C R01/09

PRE-OP LAPROSCOPIC CHOLECYSTECTOMY

IMPORTANT
Position patient ID plate so it is to the LEFT of the arrow

549328C R01/09

PHYSICIAN'S ORDER FORM

ALLERGIC: ☐ NO ☐ YES

DATE/TIME MD SIGNATURE	PHYSICIAN'S ORDERS (excludes medication orders) (check box)	NOTED BY WHOM	DATE/TIME MD SIGNATURE	MEDICATION ORDERS (includes iv's bloods, blood components) (check box)	NOTED BY WHOM
	Admit To: JB4 / Same Day Admission Unit		☐	Cefazolin (i.e. Ancef®) 1 g IV x 1 dose on induction of anesthesia	
	Admission Date:				
	Admit Diagnosis:		☐	Ibuprofen (i.e. Motrin®) 800 mg p.o. to be given on admitting unit	
	Allergies:				
	Please indicate level of care:				
	☐ Outpatient (JB4)			Please see page 2 for Vanco orders and rationale	
	☐ Outpatient Observation (24 hours)				
	Nursing				
☐	Vital signs on admission				
☐	Start IV				
☐	EKG (if not present in chart on admission)				
☐	NPO				
☐	OTHER:				
	Pre-Operative Bloodwork				
☐	Redraw: potassium if < 3.0 or > 5.0				
	HCT < 30				
	Fingerstick blood glucose on all diabetics on admission				
	to unit.				
☐	Other:				

6804

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VANCOMYCIN ORDER AND RATIONALE

IMPORTANT
Position patient ID plate so it is to the LEFT of the arrow

ALLERGIC: ☐ NO ☐ YES

DATE/TIME MD SIGNATURE	PHYSICIAN'S ORDERS (excludes medication orders)	NOTED BY WHOM	DATE/TIME MD SIGNATURE	MEDICATION ORDERS (includes iv's blood components)	NOTED BY WHOM
	If Vancomycin is the antibiotic of choice, please		☐	Vancomycin (ie Vancocin ®) 1 gm IV one dose	
	document the rationale by checking all that apply			infuse over 90 minutes. Start infusion in Pre-op	
				Line area.	
☐	Beta –Lactam, penicillin or cephalosporin allergy				
☐	Known prior colonization with MRSA				
☐	Acute inpatient hospitalization within the past year				
☐	Long Term care Resident within the past year				
☐	Increased MRSA rate, either facility-wide or procedure				
	specific				
☐	Presence of a chronic wound care or on dialysis				
☐	In-patient stay more than 24 hours prior to surgery				
☐	Other reason, please provide rationale:				
	_____				
	_____				
	_____				

PHYSICIAN'S ORDER FORM

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