ASC DAY OF SURGERY ORDERS

Physician: Height / Weight / Allergies MUST be included in order to process these orders

Height: _________, Weight: _________ (Both are required fields)

Allergies (Required): ________________________________________________________________

NURSING ORDERS

Interventions
☐ IV and IV fluids per anesthesia
☐ Other: ____________________________________________________________

MEDICATIONS

Adult Antimicrobials
☐ Antibiotics are not required for this patient
☐ ceFAZOLin 1g IVPB On Call Infuse over 30 minutes before surgery
☐ ceFAZOLin 2g IVPB On Call Infuse over 30 minutes before surgery
☐ clindamycin 600mg IVPB On Call Infuse over 30 minutes before surgery
☐ clindamycin 900mg IVPB On Call Infuse over 30 minutes before surgery
☐ gentamicin 80mg IVPB On Call Infuse over 60 minutes before surgery
☐ vancomycin 1g IVPB On Call Infuse over 60 minutes before surgery
☐ Cipro 400mg IVPB On Call Infuse over 60 minutes before surgery
☐ ceFOXitin 1 g IVPB On Call Infuse over 30 minutes before surgery

Pediatric Antimicrobials
☐ Antibiotics are not required for this patient
☐ ceFAZOLin 25mg × _________ kg = _________ mg IVPB On Call Infuse over 30 minutes before surgery
☐ clindamycin 10mg × _________ kg = _________ mg IVPB On Call Infuse over 30 minutes before surgery
☐ gentamicin 2mg × _________ kg = _________ mg IVPB On Call Infuse over 60 minutes before surgery
☐ vancomycin 10mg × _________ kg = _________ mg IVPB On Call Infuse over 60 minutes before surgery
☐ Cipro 10mg × _________ kg = _________ mg IVPB On Call Infuse over 60 minutes before surgery
☐ ceFOXitin 30mg × _________ kg = _________ mg IVPB On Call Infuse over 30 minutes before surgery

DVT Prophylaxis
☐ DVT Prophylaxis is not required
☐ heparin 5000 Units INJ SubCutaneous On Call — OR Routine Administer 1–2 hours before surgery
☐ enoxaparin 40mg INJ SubCutaneous On Call — OR Routine Administer 1–2 hours before surgery

DIAGNOSTIC TESTS
☐ Abdomen Supine (KUB) on admission to ASC
☐ Other: ____________________________________________________________

ADDITIONAL ORDERS
☐ Other: ____________________________________________________________
☐ Other: ____________________________________________________________
☐ Other: ____________________________________________________________

Provider Signature: ___________________________ ID#: _______ Date: _______ Time: _______

RN Signature: ___________________________ ID#: _______ Date: _______ Time: _______