NewYork-Presbyterian
The University Hospital of Columbia and Cornell

50705

PEDIATRIC PREOPERATIVE / PROCEDURE QUESTIONNAIRE

MRN#

NAME:

DOB: SEX:

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

GENERAL PATIENT INFORMATION (PEDIATRIC PATIENTS NEWBORN - 18 YEARS)

Date: _____/_____/_____ Time: _____ AM/PM

Name: _____ Nickname: _____

Age: _____ Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____

Legal Guardian: _____ Relationship: _____

Mother's Full Name: _____ Father's Full Name: _____

Home Phone#: (_____)_____ Work Phone #: (___)_____ Cell Phone #: (___)_____

Language(s) Spoken: _____ Translator: _____

Religion: _____ Any special religious needs: _____

Pediatrician: _____ Pediatrician Phone #: (_____)_____

Birth weight: _____ kg Current weight: _____ kg

Does your child have any allergies? ☐ NO ☐ YES ☐ FOOD ☐ DRUG ☐ LATEX ☐ OTHER _____

ALLERGY	REACTION

Please √ the following that apply:

Does your child have:

Hearing Aid	☐ No	☐ Yes
Eye Glasses	☐ No	☐ Yes
Contacts	☐ No	☐ Yes
Loose Teeth/ Chipped Teeth	☐ No	☐ Yes
Crutches	☐ No	☐ Yes
Wheelchair	☐ No	☐ Yes
Gastric Tube	☐ No	☐ Yes
Tracheostomy	☐ No	☐ Yes
Oxygen/ oximeter	☐ No	☐ Yes
Other	☐ No	☐ Yes

Does your child need help with activities of daily living? ☐ No ☐ Yes

Walking	☐ No	☐ Yes
Dressing	☐ No	☐ Yes
Eating	☐ No	☐ Yes
Transfer	☐ No	☐ Yes
Moving from Bed to Chair	☐ No	☐ Yes
Bedridden	☐ No	☐ Yes

How do you transport your child?

☐ Stroller ☐ Wheelchair ☐ Ambulatory ☐ Carried

PLEASE LIST ALL MEDICATION (INCLUDE ALL OVER THE COUNTER/ EYE DROPS/ HERBS) THAT YOUR CHILD IS CURRENTLY TAKING.

Is your child on aspirin? ☐ No ☐ Yes

Is your child taking any anticoagulation (Warfarin/ enoxaparin sodium/ heparin)? ☐ No ☐ Yes

Medication	Dose	How Often?	Last Given	Medication	Dose	How Often?	Last Given

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PAST MEDICAL HISTORY (include any chronic illnesses) / HOSPITALIZATIONS

_____

_____

_____

LIST PRIOR SURGERY/ PROCEDURES COMPLICATIONS (if any)

_____

_____

_____

_____

What previous anesthesia has your child had?

☐ None

☐ General ☐ Regional ☐ Spinal

☐ Epidural ☐ Local

Please list any complications with anesthesia

_____

_____

Any family problems with anesthesia?

_____

Was your child ever:

Treated in an intensive care unit? ☐ No ☐ Yes If yes, when & why? _____ where? _____

Seen in an Emergency Room in the last 3 months? ☐ No ☐ Yes If yes, when & why? _____ where? _____

SOCIAL INFORMATION:

Who does patient live with? _____

Are parents: ☐ married ☐ divorced ☐ separated Do parents live together? ☐ No ☐ Yes

If parents are divorced/ separated, is other parent involved? ☐ No ☐ Yes

What type of home do you live in? ☐ Apartment ☐ House Are there any stairs? ☐ No ☐ Yes How many? _____

Are there any pets in the home? ☐ No ☐ Yes If yes, what type? _____

Is there any Home Care Agency involved with your child? ☐ No ☐ Yes If yes, name of agency: _____

Contact Person: _____ Phone Number: (____)_____ Fax Number (if known): _____

Does your child attend any special programs (i.e. Down's, Early Intervention)? ☐ No ☐ Yes If yes, name of program: _____

What grade is your child in? _____ Name of School: _____ School Phone Number: (___)_____

Guidance Counselor: _____ Phone Number: (____)_____

NUTRITION:

Patient's usual diet: _____

Formula (type): _____ Amount per feeding: _____ How many feedings per day? ____ Length of feeding time? _____

☐ Breast ☐ Bottle ☐ Cup ☐ Baby Food ☐ Table Food

Appetite: ☐ Good ☐ Fair ☐ Poor

Does your child have difficulty swallowing/ sucking?	☐ No	☐ Yes
Has your child eaten less than half of their usual meal/ snack in the last 3 days?	☐ No	☐ Yes
Has your child experienced any unexplained weight loss?	☐ No	☐ Yes
Have you been told that your child is growing slower than expected?	☐ No	☐ Yes
Does your child have any wounds that have not healed?	☐ No	☐ Yes

*If yes to any of above the nurse will notify physician to determine need for further assessment.

MD notified: _____

Date: _____/_____/_____ Time: _____ AM/PM

Does your child:

use a pacifier?	☐ No	☐ Yes, specify _____
have a security object (i.e. blanket)?	☐ No	☐ Yes, specify _____
have any special bedtime/ nap needs?	☐ No	☐ Yes, specify _____
have a favorite activity/ toy?	☐ No	☐ Yes, specify _____
participate in sports/ hobbies?	☐ No	☐ Yes, specify _____

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BIRTH HISTORY (complete only if child less than 6 years of age):

Hospital where child was born: _____ Number weeks gestation: _____

Complications during pregnancy/ delivery? _____ ☐ Vaginal ☐ C- Section (reason for C-section) _____

Did your child at birth:

Have a period of breath holding?	☐ No	☐ Yes	Have a blood transfusion?	☐ No	☐ Yes
Have a breathing tube?	☐ No	☐ Yes	Appear blue ("blue baby")?	☐ No	☐ Yes
Have trouble breathing through the nose?	☐ No	☐ Yes	Have any feeding problems?	☐ No	☐ Yes
Appear yellow (jaundice)?	☐ No	☐ Yes	Other (specify): _____		

DEVELOPMENTAL DATA (complete based on your child's current age):

0 -6 Months	No	Yes	7 -15 Months	No	Yes	16 -24 Months	No	Yes
Head Control			Sits Alone			Obeys single step commands		
Visually follows objects			Crawls			Vocabulary of 10 words		
Lifts head when in prone position			Babbles/ utters sounds			Climbs stairs		
Smiles			Waves good- bye			Knows simple body parts		
Reaches			Pulls to standing position			Uses utensils		
Coos						Scribbles		
Looks at own hands								
Turns to parent's voice								

24 Months - 3 Years	No	Yes	3 -5 Years	No	Yes	Special Concerns	No	Yes
Helps get self dressed			Dresses self			Do you have any special		
Able to wash and dry own hands			Prepares own cereal			concerns about your child's		
Able to draw in a straight line			Able to copy a circle			development? If yes, explain		
Combines words			Know to count to 10					
Jumps up vertically			Speaks in full sentences					
Throws ball			Hops on one foot					
Words understandable to strangers								

HEART:

Does your child have:

Heart disease?	☐ No	☐ Yes	If yes, please explain _____
Heart murmur?	☐ No	☐ Yes	If yes, please explain _____
Chest pain?	☐ No	☐ Yes	What usually causes the pain? _____ How often? _____
Mitral valve prolapse?	☐ No	☐ Yes	If yes, please explain _____
Irregular heartbeat?	☐ No	☐ Yes	If yes, please explain _____
Rheumatic fever?	☐ No	☐ Yes	If yes, please explain _____
A pacemaker?	☐ No	☐ Yes	If yes, please explain _____
High blood pressure?	☐ No	☐ Yes	If yes, please explain _____
High cholesterol/ lipids?	☐ No	☐ Yes	If yes, please explain _____

Have you ever been told your child needs to take antibiotics prior to a procedure/ dental work? ☐ No ☐ Yes

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BREATHING:

Does your child:

Get short of breath?	☐ No	☐ Yes	
Have asthma or wheezing?	☐ No	☐ Yes	
Have BPD (bronchopulmonary dysplasia)?	☐ No	☐ Yes	
Have a productive cough?	☐ No	☐ Yes	If yes, for how long?_____
Have a history of pneumonia?	☐ No	☐ Yes	If yes, when? _____
Have a history of RSV or bronchiolitis?	☐ No	☐ Yes	
Does your child snore?	☐ No	☐ Yes	
Has your child had a recent cough or cold in the past 2 weeks?	☐ No	☐ Yes	If yes, MD notified:_____ Date: _____/_____/_____ Time: _____ AM/PM

Does your child have:

Difficulty breathing during sleep?	☐ No	☐ Yes	
Restless sleep?	☐ No	☐ Yes	
Breathe through his/her mouth when awake?	☐ No	☐ Yes	
Have you observed symptoms of apnea?	☐ No	☐ Yes	
Have you observed sweating while child sleeps?	☐ No	☐ Yes	
Do you any family history of obstructive sleep apnea, sudden infant death syndrome, or apparent life threatening events?	☐ No	☐ Yes	

DIGESTION/ ELIMINATION:

Does your child have:

Chronic stomach ache/pain	☐ No	☐ Yes	
Reflux (GERD)?	☐ No	☐ Yes	
Colitis?	☐ No	☐ Yes	
Diarrhea frequently?	☐ No	☐ Yes	
Constipation frequently?	☐ No	☐ Yes	
Urinary tract infections/kidney problems?	☐ No	☐ Yes	
A stoma?	☐ No	☐ Yes	
An umbilical, inguinal, or hiatal hernia?	☐ No	☐ Yes	
A diaper rash?	☐ No	☐ Yes	If yes, how do you treat it? _____
Nausea?	☐ No	☐ Yes	If yes, for how many days?_____
Is your child toilet trained?	☐ No	☐ Yes	If yes, term used: _____
Last bowel movement _____			

MUSCULOSKELETAL/ SKIN:

Does your child:

Move all extremities without difficulty?	☐ No	☐ Yes
Have chronic muscle/ joint pain?	☐ No	☐ Yes
Have any weakness in arms or legs?	☐ No	☐ Yes
Have any areas of skin redness/ rash or skin breakdown?	☐ No	☐ Yes
Have any bone fractures?	☐ No	☐ Yes
Have scoliosis?	☐ No	☐ Yes

ENDOCRINE DISEASE:

Does your child have:

Diabetes?	☐ No	☐ Yes	
Hypoglycemic (low blood sugar)?	☐ No	☐ Yes	
Metabolic disease?	☐ No	☐ Yes	If yes, specify: _____
Thyroid disease?	☐ No	☐ Yes	

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NEUROLOGIC:

Has your child had:

Stroke?	☐ No	☐ Yes	Headaches?	☐ No	☐ Yes
Seizures?	☐ No	☐ Yes	Fainting spells?	☐ No	☐ Yes
Learning disabilities?	☐ No	☐ Yes	Speech difficulties?	☐ No	☐ Yes
Dizziness?	☐ No	☐ Yes	Hearing loss?	☐ No	☐ Yes
Difficulty seeing?	☐ No	☐ Yes			

Has your child ever been diagnosed with a genetic or chromosomal syndrome? ☐ No ☐ Yes If yes, specify_____

CANCER:

Has your child:

Been diagnosed with cancer? ☐ No ☐ Yes If yes, specify_____

Received radiation/ chemotherapy? ☐ No ☐ Yes If yes, last treatment_____

Placed on isolation / special precautions? ☐ No ☐ Yes If yes, specify_____

COMMUNICABLE DISEASES:

Has your child been exposed within the last 3 weeks to:

Chicken pox?	☐ No	☐ Yes	Mumps?	☐ No	☐ Yes
Measles?	☐ No	☐ Yes	Hepatitis?	☐ No	☐ Yes
Tuberculosis?	☐ No	☐ Yes			

Are your child's immunizations up to date? ☐ No ☐ Yes If no, explain _____

BLOOD/ TRANSFUSIONS:

Does your child have?

Bleeding problems?	☐ No	☐ Yes	Bruise easily?	☐ No	☐ Yes
Sickle cell trait/ disease?	☐ No	☐ Yes	Anemia?	☐ No	☐ Yes

Do you refuse blood transfusions? ☐ No ☐ Yes

Has your child ever had a transfusion reaction? ☐ No ☐ Yes

PARENT/ GUARDIAN SIGNATURE: _____

DATE: _____/_____/_____ Time: _____ AM/PM

TO BE COMPLETED BY R.N. (If interviewed prior to day of surgery)

METHOD OF INTERVIEW: ☐ Face to Face ☐ Telephone

INFORMANT: ☐ Patient ☐ Parent/ Legal Guardian

DIAGNOSIS: _____

PROCEDURE: _____

DATE: _____/_____/_____ **TIME:** _____ AM/PM

T _____ °C **P** _____ **R** _____ **BP** _____ **Ht** _____ cm **Wt** _____ kg

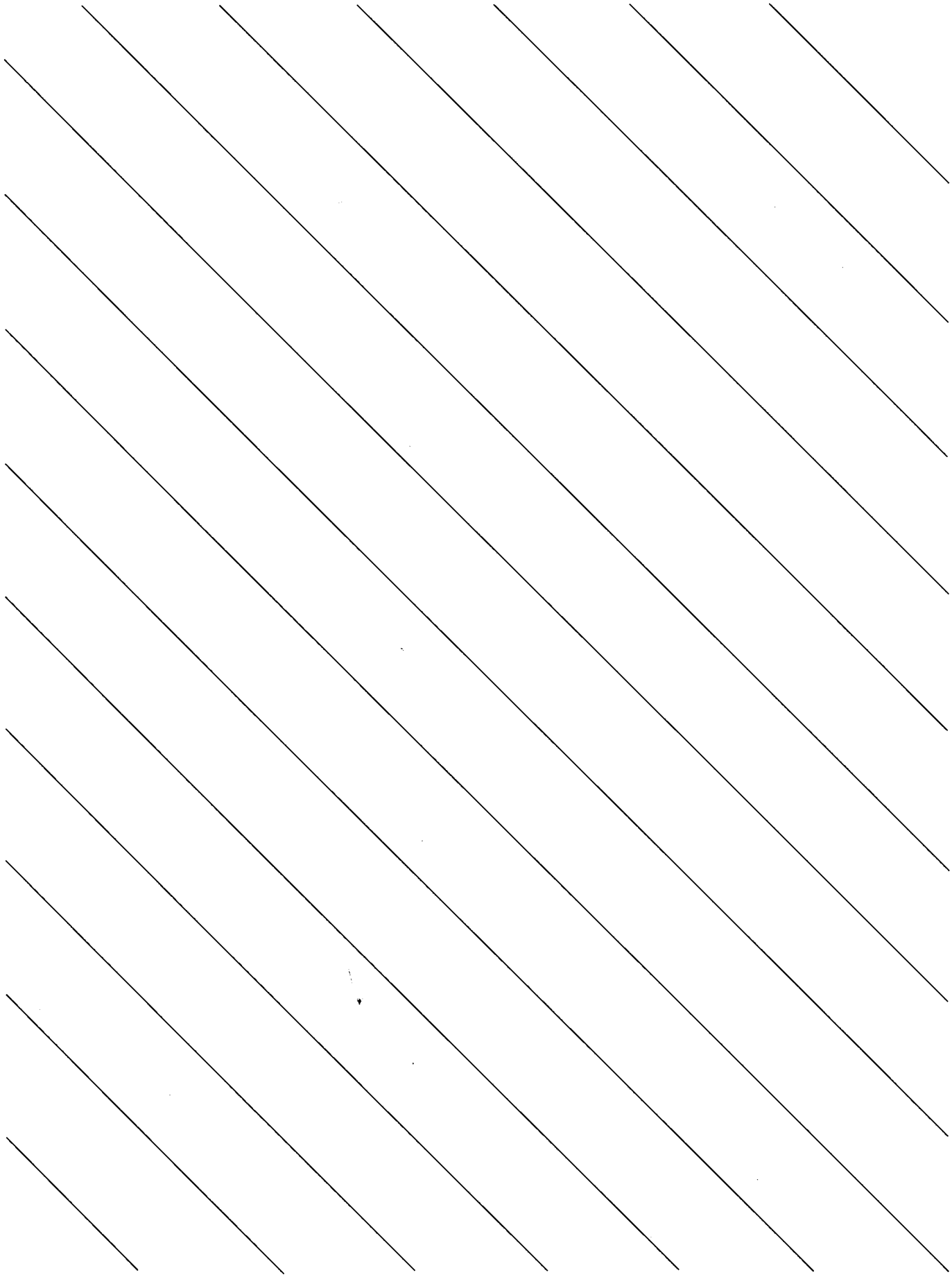
Form Reviewed by _____ **RN** **DATE:** ____/____/_____

Signature

TIME: _____ AM/PM

_____ **ID Code:** _____

Print Name



NewYork-Presbyterian
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MRN#

NAME:

DOB: SEX:

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

PRE-OP TESTING DOCTOR'S ORDERS / PEDIATRICS

AUTOMATIC STOP ORDER POLICY	RE-ORDER TIME	AUTOMATIC STOP ORDER POLICY	RE-ORDER TIME
Intravenous fluids (for fluid replacement) Other large volume parenterals / Irrigations All controlled substances (including epidural infusions and patient controlled analgesia)	7 days	All medications (including intravenous and oral antibiotics) Warfarin	30 days 24 hours for the first 7 days, after that orders will be valid for 7 days if the patient is within therapeutic range

LEGIBILITY and COMPLETENESS of medication orders counts - Please follow these Guidelines:

- Write out "units"
- Use leading zero, eg. 0.1 mg
- Write out "days" or "doses"
- Write out "microgram"
- Omit trailing zero, eg. 1 mg
- Print medication order
- Print name and ID code
- Sign all orders
- Add beeper number

DATE	TIME	DOCTOR'S ORDERS AND DOCTOR'S SIGNATURE	ORDER POSTED BY WHOM DATE, TIME	ORDER CHECKED BY RN DATE, TIME	ORDER FAXED DATE, TIME
		*ALLERGIC/SENSITIVE TO: Pediatric Pre-op Testing Order(s) ☐ Type & Cross per Maximum Surgical / Blood Order Schedule The link is: http://infonet.nyporg/Lab/Transfusio/Index.asp ☐ Type & Screen per Maximum Surgical / Blood Order Schedule The link is: http://infonet.nyporg/Lab/Transfusio/Index.asp Signature: _____ MD, PA, NP Print Name/I.D. Code: _____			

(*) Required only for admissions, transfers where Graduate Staff coverage changes, and when new allergies are identified.

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☐ SDS
☐ AS

MRN#

NAME:

DOB: SEX:

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

PERIOPERATIVE SERVICES / HISTORY & PHYSICAL DAY OF SURGERY ORDERS

Date: _____/_____/_____ **Time:** _____ **AM/PM**

SUBMIT THIS DOCUMENTATION AND ALL TEST RESULTS TO THE PRESURGICAL DOCUMENTATION CENTER NO LATER THAN 2 DAYS PRIOR TO THE DATE OF SURGERY

PATIENT NAME:	ADMISSION DIAGNOSIS: (1)	
HISTORY NUMBER: (UNCONFIRMED) AGE: DOB:	SECONDARY DIAGNOSIS: (2)	
FATHER'S FULL NAME:	PROCEDURE/OPERATION:	
REFERRING PHYSICIAN NAME:	PROCEDURE DATE: _____/_____/_____	CONFIRMATION #:
GOING TO PAT ☐ YES ☐ NO PREADMISSION TESTING DATE: _____/_____/_____ PAT AT NYPH? ☐ YES ☐ NO Where _____	PRINT SURGEON NAME/ID CODE:	

HISTORY AND PHYSICAL

HISTORY OF PRESENT ILLNESS (HPI):
Specific Surgical in PI: Narrative HPI

HISTORY:

Past Surgical History:

Surgery	Date
	/ /
	/ /
	/ /
	/ /

Past Medical History:

Condition	Date
	/ /
	/ /
	/ /
	/ /

Medications: List of Medications (including over -the-counter medications): (Complete Medication Reconciliation form - 51187)

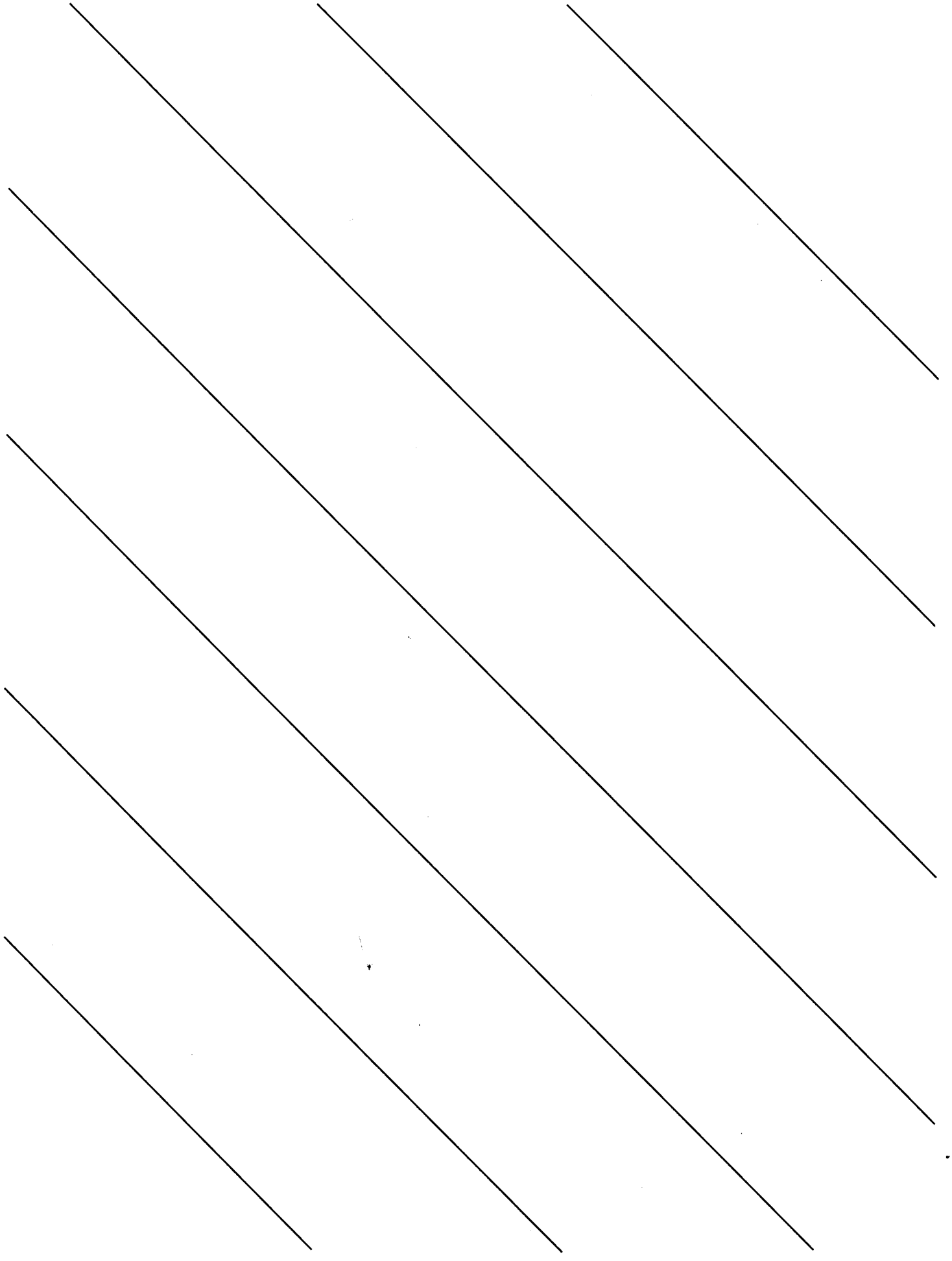
Medications	Dosage	Frequency

Family History: ☐ Heart Attack ☐ Cancer ☐ Colon Problems ☐ Other _____ ☐ None

Do you have allergies? Yes No FOOD DRUG LATEX OTHER _____

ALLERGEN	REACTION

50173 (9/11)



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PERIOPERATIVE SERVICES / HISTORY & PHYSICAL
DAY OF SURGERY ORDERS

MRN#

NAME:

DOB: SEX:

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REVIEW OF SYSTEMS:

	Normal	Abnormal	Describe Abnormal findings
Constitution	☐	☐	☐ Fever ☐ Weight loss ☐ Other _____
Cardiovascular	☐	☐	☐ Heart attack ☐ Chest pain ☐ Mitral valve prolapse ☐ Hypertension ☐ Claudication ☐ Other _____
Respiratory	☐	☐	☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Cough ☐ SOB ☐ Other ___
Gastrointestinal	☐	☐	☐ GERD ☐ Peptic Ulcer disease ☐ Diverticulitis ☐ Irritable bowel ☐ Hepatitis ☐ Cirrhosis ☐ Hypercholesteremia ☐ Gall Bladder disease ☐ Other _____
Genitourinary	☐	☐	☐ Renal Failure ☐ Other _____
Musculoskeletal	☐	☐	☐ Rheumatoid arthritis ☐ Other _____
Neurologic	☐	☐	☐ Stroke ☐ Other _____
Psychiatric	☐	☐	☐ Depression ☐ Anxiety ☐ Bipolar ☐ Other _____
Endocrine/Metabolic	☐	☐	☐ Diabetes ☐ Lupus ☐ Thyroid disease ☐ Other _____
Hematologic/Lymphatic	☐	☐	☐ Anemia ☐ Other _____
Substance Abuse	☐ No	☐ Yes	substance _____ last used : ____/____/____
Smoking	☐ No	☐ Yes	when quit : ____/____/____ ppd: _____
Cancer	☐ No	☐ Yes	_____
Other	☐	☐	_____

PHYSICAL EXAM: (check all that apply)

CONSTITUTIONAL:

VS: Temp _____°C Pulse _____ Respiration _____ BP _____ Height _____(cm) Weight _____(kg)

General Appearance ☐ Normal ☐ Malnourished ☐ Overweight ☐ Obese ☐ Morbidly obese

EYES

Inspection of conjunctiva, lids: ☐ Normal ☐ Icteric conjunctiva ☐ periorbital edema ☐ abnormal sclerae ☐ Other _____

Examination of pupils/iris: ☐ PERRLA ☐ Other: _____

NECK

Overall appearance: ☐ Normal **Masses:** ☐ None ☐ Lymph nodes _____ ☐ JVD ☐ Other: _____

Thyroid: ☐ Normal ☐ Other: _____

RESPIRATORY

Effort: ☐ Normal ☐ Tachypneic ☐ Use of accessory muscles ☐ Other: _____

Lungs (Auscultation): ☐ Normal ☐ Other _____

CARDIOVASCULAR

Auscultation of Heart: ☐ Normal ☐ Murmur ☐ Other _____

Examination of Extremities: ☐ Normal ☐ Venous insufficiency ☐ Varicose veins ☐ Edema ☐ Other _____

GASTROINTESTINAL

Examination of Abdomen: ☐ Normal ☐ Masses _____ ☐ Tenderness _____

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PERIOPERATIVE SERVICES / HISTORY & PHYSICAL
DAY OF SURGERY ORDERS

MUSCULOSKELETAL:
Examination of Gait and Station: ☐ Normal ☐ Abnormal _____
Assessment of Strength and Tone: ☐ Normal ☐ Atrophy _____ Tremor _____ ☐ Other _____

SKIN
Inspection: ☐ Normal ☐ Erythema ☐ Stasis dermatitis ☐ Jaundice ☐ Ulcer _____
☐ Other _____
Palpation: ☐ Normal ☐ Induration ☐ subq nodules ☐ Other _____

NEUROLOGICAL/PSYCHIATRIC
Orientation: ☐ Normal ☐ Other _____
Mood: ☐ Normal ☐ Other _____

DIAGNOSIS:

PLAN FOR SURGERY:

INFECTION PRIOR TO ANESTHESIA/PRINCIPAL PROCEDURE/SURGERY START TIME

☐ Yes, Preoperative Infection exists

☐ Yes, Suspected / Possible Preoperative Infection exists

☐ No

JUSTIFICATION / REASON FOR VANCOMYCIN USE: (check all that apply)

☐ Beta-lactam (penicillin or cephalosporin) allergy
☐ High-risk due to acute inpatient hospitalization within the last year
☐ High-risk due to nursing home or extended care facility setting within the last year, prior to admission
☐ Inpatient stay more than 24 hours prior to the principal procedure
☐ Transferred from another inpatient hospitalization after a 3-day stay
☐ MRSA colonization or infection
☐ Chronic wound care or dialysis
☐ Increase MRSA rate, either facility-wide or operation-specific
☐ Undergoing valve surgery
☐ Not Applicable

Signature: _____ MD/PA/NP Date: ____/____/____ Time: _____ AM/PM

Print Name: _____ ID CODE # _____

Reviewed by Attending Surgeon: _____ MD Date: ____/____/____ Time: _____ AM/PM

Print Name: _____ ID CODE # _____

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PERIOPERATIVE SERVICES / HISTORY & PHYSICAL
DAY OF SURGERY ORDERS / ADULTS

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Date: ____/____/____ **Time:** _____ AM/PM **PATIENT HEIGHT:** _____ cm **PATIENT WEIGHT:** _____ kg

PATIENT ALLERGIES/TYPE OF REACTION: ☐ None ☐ Latex ☐ Beta-Lactam Allergy/Penicillin Allergy/Cephalosporin Allergy
☐ Other (specify): _____ Reaction: _____

AUTOMATIC INTERNAL CARDIAC DEFIBRILLATOR - NOTIFY ELECTROPHYSIOLOGY FELLOW TO SEE PATIENT DAY OF SURGERY

IV FLUID (Type and Rate):

☐ **NA**

PAIN MANAGEMENT CONSULT ☐ **YES** ☐ **NO**
PCA INDICATED POSTOP ☐ **YES** ☐ **NO**
Epidural Indicated day of surgery ☐ **YES** ☐ **NO**

ADULT PRE-OP ANTIBIOTICS ☐ **NO PRE-OP ANTIBIOTICS NEEDED** *(Check all that apply) Optimal administration within 15-60 minutes prior to incision. Vancomycin administration may begin within 2 hours prior to incision.* **(USE Cefazolin 2 g FOR PATIENTS WEIGHING >80 kg)**

NATURE OF OPERATION	PRIMARY ANTIBIOTIC PROPHYLAXIS RECOMMENDED	ALTERNATIVE (e.g. Penicillin/Sulfa Allergy)
CARDIAC: CABG, other open-heart	Cefazolin ☐ 1 g **OR** ☐ 2 g IV X 1	☐ Vancomycin 1 g IV X 1
Prosthetic valve	Cefazolin ☐ 1 g **OR** ☐ 2 g IV X 1 ± ☐ Gentamicin _____ mg (1.5 mg/kg, LBW[1]) IV X 1	☐ Vancomycin 1 g IV X 1 ± ☐ Gentamicin _____ mg (1.5 mg/kg (LBW[1]) IV X 1
Pacemaker, defibrillator placement	Cefazolin ☐ 1 g **OR** ☐ 2 g IV X 1	☐ Clindamycin 600 mg IV X 1 **OR** ☐ Vancomycin 1 g IV X 1
GASTRO-INTESTINAL, GYNECOLOGIC AND OBSTETRIC:	Cefazolin ☐ 1 g **OR** ☐ 2 g IV X 1 **OR** ☐ Cefoxitin 2 g IV X 1 *(for cesarean delivery, may be administered prior to incision or after cord clamping)*	☐ Clindamycin 600 mg IV + Gentamicin _____ mg (1.5 mg/kg, LBW[1]) IV X 1 *(for cesarean delivery, may be administered prior to incision or after cord clamping)*
Bariatric surgery	Cefazolin ☐ 2 g **OR** ☐ 3 g IV X 1 ± ☐ Metronidazole 500 mg IV X 1	☐ Clindamycin 900 mg IV X 1
Colorectal, appendectomy non-perforated	☐ Cefazolin 1-2 g IV + metronidazole 500 mg IV X 1 **OR** ☐ Cefoxitin 2 g IVP X 1	☐ Clindamycin 600 mg IV + Gentamicin _____ mg (1.5 mg/kg, LBW[1]) IV X 1
GENITOURINARY: Endoscopic Procedures	Cefazolin ☐ 1 g **OR** ☐ 2 g IV X 1 **OR** ☐ Ampicillin 2 g IV + Gentamicin _____ mg (1.5 mg/kg, LBW[1]) IV X 1	☐ Clindamycin 600 mg IV + Gentamicin _____ mg (1.5 mg/kg, LBW[1]) IV X 1
Open or Laparoscopic surgery	Cefazolin ☐ 1 g **OR** ☐ 2 g IV X 1	☐ Clindamycin 600 mg IV + Gentamicin _____ mg (1.5 mg/kg, LBW[1]) IV X 1
Transrectal prostate biopsy **Pubo-Vaginal Sling**	☐ Cefoxitin 2 g IV X 1 **OR** ☐ Levofloxacin 500 mg PO X 1 (Taken at home as prescribed)	☐ Clindamycin 600 mg IV + Gentamicin _____ mg (1.5 mg/kg, LBW[1]) IV X 1 **OR** ☐ Levofloxacin 500 mg PO X 1 (Taken at home as prescribed)
Penile prosthesis insertion, removal, revision	☐ Vancomycin 1 g IV X 1 + Gentamicin _____ mg (1.5 mg/kg, LBW[1]) IV X 1	☐ Clindamycin 600 mg IV + Gentamicin _____ mg (1.5 mg/kg, LBW[1]) IV X 1
HEAD AND NECK:	Cefazolin ☐ 1 g **OR** ☐ 2 g IV X 1	☐ Clindamycin 600 mg IV + Gentamicin _____ mg (1.5 mg/kg, LBW[1]) IV X 1
NEUROSURGERY, THORACIC, VASCULAR:	Cefazolin ☐ 1 g **OR** ☐ 2 g IV X 1	☐ Vancomycin 1 g IV X 1
ORTHOPEDIC	Cefazolin ☐ 1 g **OR** ☐ 2 g IV X 1	☐ Vancomycin 1 g IV X 1 **OR** ☐ Clindamycin 600 mg IV X 1
TRANSPLANTS: Heart, Kidney	Cefazolin ☐ 1 g **OR** ☐ 2 g IV X 1	☐ Vancomycin 1 g IV X 1
Lung	☐ Ampicillin/Sulbactam 3 g IV X 1	☐ Vancomycin 1 g IV + Aztreonam 1 g IV X 1
Liver	☐ Ampicillin/Sulbactam 3 g IV X 1	☐ Vancomycin 1 g IV + Aztreonam 1 g IV + Metronidazole 500 mg IV X 1
LVAD	☐ Rifampin 600 mg IV + Fluconazole 400 mg IV + TMP/SMX 160 mg (TMP) IV X 1	☐ Rifampin 600 mg IV + Fluconazole 400 mg IV + Vancomycin 1 g IV X 1
Pancreas or kidney/pancreas	☐ Ampicillin/Sulbactam 3 g IV + Fluconazole 400 mg IV X 1	☐ Clindamycin 600 mg IV + Aztreonam 1 g IV + Fluconazole 400 mg IV X 1

1 LBW: lean body weight

VTE PHARMACOPROPHYLAXIS: (Route, dose, time): (check all that apply)
☐ HEPARIN 5000 UNITS SQ X1 _____
☐ OTHER _____
☐ PATIENT EVALUATED & DOES NOT REQUIRE VTE PHARMACOPROPHYLAXIS

OTHER MEDICATION (Route, dose & time)

Signature: _____ MD/PA/NP Date: ____/____/____ Time: _____ AM/PM
Print Name: _____ ID CODE # _____

DAY OF SURGERY UPDATE

☐ An updated assessment and examination of the patient was completed and there was no change
☐ An updated assessment and examination of the patient was completed and the changes are: _____

Day of Surgery Note/Plan of Care _____

Signature: _____ MD Date: ____/____/____ Time: _____ AM/PM
Print Name: _____ ID CODE # _____

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

MRN#

NAME:

DOB: SEX:

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

PERIOPERATIVE SERVICES / HISTORY & PHYSICAL
DAY OF SURGERY ORDERS / PEDIATRICS

Date: ____/____/____ **Time:** ____ AM/PM **PATIENT HEIGHT:** ____ cm **PATIENT WEIGHT:** ____ kg

PATIENT ALLERGIES/TYPE OF REACTION:
☐ None ☐ Latex ☐ Other (specify) : ____
Reaction: ____

IV FLUID (Type and Rate):
☐ **N/A**

PAIN MANAGEMENT CONSULT ☐ **YES** ☐ **NO**
PCA INDICATED POSTOP ☐ **YES** ☐ **NO**
Epidural Indicated day of surgery ☐ **YES** ☐ **NO**

PEDIATRICS PRE-OP ANTIBIOTICS ☐ **NO PRE-OP ANTIBIOTICS NEEDED**
(Check all that apply) Optimal administration within 15-60 minutes prior to incision. Vancomycin administration may begin within 2 hours prior to incision.

NATURE OF OPERATION	PRIMARY ANTIBIOTIC PROPHYLAXIS RECOMMENDED	ALTERNATIVE (e.g. Penicillin/Sulfa Allergy)
CARDIAC: Prosthetic valve, coronary artery bypass, other open-heart	☐ Cefazolin ____mg (30 mg/kg/dose, max 2 grams) IV X 1	☐ Vancomycin ____mg (15 mg/kg/dose, max 1 gram) IV X 1
Pacemaker, defibrillator placement	☐ Cefazolin ____mg (30 mg/kg/dose, max 2 grams) IV X 1	☐ Clindamycin ____mg (10 mg/kg/dose, max 900 mg) IV X 1 **OR** ☐ Vancomycin ____mg (15 mg/kg/dose, max 1 gram) IV X 1
GASTRO-INTESTINAL, GYNECOLOGIC AND OBSTETRIC:	☐ Cefazolin ____mg (30 mg/kg/dose, max 2 grams) IV X 1 **OR** ☐ Cefoxitin ____mg (30 mg/kg/dose, max 2 grams) IV X 1	☐ Clindamycin ____mg (10 mg/kg/dose, max 900 mg) IV + Gentamicin ____mg (2 mg/kg/dose, LBW[1]) IV X 1
Colorectal, appendectomy non-perforated	☐ Cefoxitin ____mg (30 mg/kg/dose, max 2 grams) IV X 1 **OR** ☐ Cefazolin ____mg (30 mg/kg/dose, max 2 grams) IV X 1 ☐ Metronidazole ____mg (7.5 mg/kg/dose, max 500 mg) IV X1	☐ Clindamycin ____mg (10 mg/kg/dose, max 900 mg) IV + Gentamicin ____mg (2 mg/kg/dose, LBW[1]) IV X 1
GENITOURINARY: Endoscopic Procedures	☐ Cefazolin ____mg (30 mg/kg/dose, max 2 grams) IV X 1 **OR** ☐ Ampicillin ____mg (50 mg/kg/dose, max 1 gram) IV + Gentamicin ____mg (2 mg/kg/dose, LBW[1]) IV X 1	☐ Clindamycin ____mg (10 mg/kg/dose, max 900 mg) IV + Gentamicin ____mg (2 mg/kg/dose, LBW[1]) IV X 1
Open or Laparoscopic surgery	☐ Cefazolin ____mg (30 mg/kg/dose, max 2 grams) IV X 1	☐ Clindamycin ____mg (10 mg/kg/dose, max 900 mg) IV + Gentamicin ____mg (2 mg/kg/dose, LBW[1]) IV X 1
HEAD AND NECK:	☐ Cefazolin ____mg (30 mg/kg/dose, max 2 grams) IV X 1	☐ Clindamycin ____mg (10 mg/kg/dose, max 900 mg) IV + Gentamicin ____mg (2 mg/kg/dose, LBW[1]) IV X 1
NEUROSURGERY, THORACIC, VASCULAR:	☐ Cefazolin ____mg (30 mg/kg/dose, max 2 grams) IV X 1	☐ Vancomycin ____mg (15 mg/kg/dose, max 1 gram) IV X 1
ORTHOPEDIC:	☐ Cefazolin ____mg (30 mg/kg/dose, max 2 grams) IV X 1	☐ Vancomycin ____mg (15 mg/kg/dose, max 1 gram) IV X 1 **OR** ☐ Clindamycin ____mg (10 mg/kg/dose, max 900 mg) IV X 1
TRANSPLANTS: Heart, Kidney	☐ Cefazolin ____mg (30 mg/kg/dose, max 2 grams) IV X 1	☐ Vancomycin ____mg (15 mg/kg/dose, max 1 gram) IV X 1
Lung	☐ Ampicillin/Sulbactam ____mg (50 mg/kg/dose, max 2 grams) IV X 1	☐ Vancomycin ____mg (15 mg/kg/dose, max 1 gram) IV + Aztreonam ____mg (30 mg/kg/dose, max 1 gram) IV X 1
Liver	☐ Ampicillin/Sulbactam ____mg (50 mg/kg/dose, max 2 grams) IV X 1	☐ Vancomycin ____mg (15 mg/kg/dose, max 1 gram) IV + Aztreonam ____mg (30 mg/kg/dose, max 1 gram) IV + Metronidazole ____mg (7.5 mg/kg/dose, max 500 mg) IV X 1
Small Bowel	☐ Ampicillin/Sulbactam ____mg (50 mg/kg/dose, max 2 grams) IV + Fluconazole ____mg (6 mg/kg/dose, max 400 mg) IV X 1	☐ Vancomycin ____mg (15 mg/kg/dose, max 1 gram) IV + Aztreonam ____mg (30 mg/kg/dose, max 1 gram) IV + Metronidazole ____mg (7.5 mg/kg/dose, max 500 mg) IV + Fluconazole ____mg (6 mg/kg/dose, max 400 mg) IV X 1

1 LBW: lean body weight

Signature: ____ MD/PA/NP Date: ____/____/____ Time: ____ AM/PM
Print Name: ____ ID CODE # ____

DAY OF SURGERY UPDATE

☐ An updated assessment and examination of the patient was completed and there was no change
☐ An updated assessment and examination of the patient was completed and the changes are: ____

Day of Surgery Note/Plan of Care ____

Signature: ____ MD Date: ____/____/____ Time: ____ AM/PM
Print Name: ____ ID CODE # ____