UC Irvine Health

AMBULATORY PRACTICE
SURGICAL SCHEDULING ORDERS

Patient Information

Date:	Time:	Surgeon(s): Dr. Garrett Wirth	
Patient Telephone ___-___-___	STARS #:	Date of Surgery: ___/___/___	Time of Surgery: ___:___
Clinic Coordinator:	Nurse:	Office Ext.:	Fax #:
Height (cm):	Weight (kg):	VS: BP___ P___ R___ T___	Primary Care MD:
Allergies:		Reaction:	

☐ Patient Does Not Require Medical Clearance
☐ Referral for Medical Evaluation ☐ Hospitalist Program Fax: 714.456.6429 H & P Source ☐ UC Irvine ☐ Outside ☐ UCI preop appt/time
☐ Other MD: Name: Office Number: Appt. Date
☐ Give Reasons: Clinical Staff Signature: Date/Time:
☐ Primary Surgeon to provide orders and pre-operative work up

Physician Orders

☐ UC Irvine Lab ☐ Outside Lab: ☐ CBC w/diff ☐ Hgb/Hct ☐ ACT ☐ PT ☐ PTT ☐ BMP ☐ CMP ☐ UA ☐ Urine C&S ☐ BHCG ☐ UA Preg
☐ STAT ☐ T & H **Bleeding Questionaire Positive** ☐ Yes ☐ No **See Pre Op Testing Guidelines**
☐ T & C ___units ☐ T & H ___units ☐ Directed Donor ☐ Autologous ☐ Blood Bank ☐ EKG < 6 mo X-Ray: ☐ Chest PA/LAT
Patient Acknowledgement of Specimen(s) Taken for Laboratory Testing Listed above:
Name (print): Signature: Date: Relationship to patient:

Diagnosis: **ICD9:**

Surgical Procedure (as per informed consent) Length of procedure cut/close: **CPT:**

Procedure part of IRB Protocol: ☐ No ☐ Yes IRB# ☐ Major ☐ Minor
Prior Cardiac W/U ☐ ☐ Diagnostic Tests Results / Images Required in Procedure Area: **Bleeding Risk** ☐ High ☐ Low

Anesthesia Preference: ☐ Choice ☐ General ☐ Epidural ☐ Regional ☐ MAC ☐ Other
Positioning: ☐ Supine ☐ Prone ☐ Rt. Lateral ☐ Lt. Lateral ☐ Lithotomy ☐ Allen Stirrups ☐ Candy Canes ☐ Other
Special Equipment or Supplies: ☐ C-ARM ☐ Cell-Saver ☐ Spinal Monitoring ☐ Prosthesis ☐ Bone ☐ Tissue ☐ Ultrasound ☐ Laser:type
VTE Prophylaxis: ☐ SCDs ☐ TEDs ☐ **Thigh High (preferred)** ☐ **Knee High**
In Preop: ☐ Enoxaparin ___ mg Subcut x 1 ☐ Heparin ___ Units Subcut x 1 ☐ Other
Cardiac Prophylaxis with Beta Blocker: **(Beta Blocker Criteria listed on back panel.)**
Beta Blocker: ___ **orally with sips of water with pre-op meds**

Prophylaxis is Indicated or Patient Already on Beta-Blocker
☐ Patient is already on beta-blocker therapy and will take this prior to surgery
☐ Patient meets criteria and was prescribed a beta-blocker to take prior to surgery
☐ Patient meets criteria, but beta-blocker NOT prescribed due to HR<55 or SBP<100
If prophylaxis is indicated or the patient is already on a beta-blocker and HR>65 and SBP>100 prior to induction:
☐ Give additional dose of IV metoprolol 2.5 -5 mg and repeat in 15 minutes to target HR 55-65.

Prophylaxis is Not Indicated
☐ Patient does NOT meet criteria for beta-blocker prophylaxis because patient is scheduled for low-risk surgery or non-AAA surgery with <2 RCRI criteria
☐ Beta-blocker NOT prescribed due to allergy or other major contraindication

Antibiotics: ☐ Antibiotics not indicated
☐ Antibiotic dosage appropriate for weight per pharmacy
☐ MD aware of patient allergy. Proceed with ordered antibiotic.

Adult Dosage
☐ Cefazolin IVPB
☐ Cefoxitin IVPB
☐ Ampicillin IVPB
☐ Ampicillin/Sulbactam IVPB
☐ Clindamycin IVPB + Gentamycin IVPB
☐ Clindamycin IVPB + Ciprofloxacin IVPB
☐ Ertapenem IVPB 1 gm for:
☐ Open Heart Surgery or ☐ Colorectal Surgery
☐ Clindamycin
☐ Gentamicin ___ mg IVPB (1.8 - 2.5mg/kg)
☐ Ciprofloxacin 400mg IVPB (for pt. allergic to Penicillin)
☐ Metronidazole 500mg IVPB
☐ Other

REASONS: MUST check all that apply for prescribing Vancomycin:
☐ Beta-lactam allergy
☐ Continuous inpatient stay > 24hrs prior to the principal procedure
☐ Known MRSA colonization
☐ High risk due to acute inpatient care or LTC within past year
☐ Chronic wound care ☐ Chronic dialysis
☐ Prosthetic valve or vascular graft surgery
☐ Skin lesions concerning for possible community-acquired MRSA
☐ Other reason:

Vancomycin ___ gm (15mg/kg up to 1.5gm rounded to nearest 250 mg) in D5W IVPB
☐ Concentrated Vancomycin for craniotomy and CT surgery patients only
☐ Vancomycin 1.5 gm in NS\D5W 150ml
☐ Vancomycin 1.25 gm in NS\D5W 150ml
☐ Vancomycin 1.5 gm in NS\D5W 150ml
(NS for craniotomy patients. D5W for CT surgery patients.)

Admission Requirements Nursing Unit: Type of Admission: ☐ Elective ☐ Urgent ☐ Emergent Estimated # of midnights
☐ Inpatient (PRE & AM Admits) Rationale: ☐ Status post surgery, inpatient stay required for ongoing medical management
☐ Outpatient Surgery / No Post Surgical Bed Needed ☐ Outpatient Surgery / Post Surgical Bed Required ☐ Isolation (give reason):
DISCHARGE PLACEMENT: ☐ SNF/Rehab/HH ☐ Home ☐ Unknown
Communication Notes:

MD/PA/NP Signature: Date/Time: Attending MD Signature: Date/Time:

All documentation must indicate the specific date and time of entry and a signature complete with identify credential, title or classification.

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UC Irvine Health

PREOPERATIVE ANESTHESIA SCREENING

DOB: ____/____/____ Age: _____ Gender: ☐M ☐F Wt: _____ lb. Ht: _____ in.
Email Address: _____
Primary MD: _____ Last Visit: _____ Surgeon: _____
Previous Surgery at UC Irvine Health? ☐Y ☐N Best time to call: _____ Best number to reach you (____) _____
Best time for Pre Op Visit: _____ Pre Op Phone Interview: _____
Will you be arriving from out of the area? ☐Y ☐N If yes, from where? _____

Patient Questionnaire

Please answer the following YES or NO questions to the best of your ability. If you are unsure, or have comments, please note the question in the comments at the end of each section.

CARDIOVASCULAR	YES	NO	Year
High Blood Pressure	☐	☐	
*Heart Attack	☐	☐	
*Angina/chest pain	☐	☐	
Heart Bypass surgery	☐	☐	
CABG	☐	☐	
*Stents	☐	☐	
Pacemaker or Defibrillator	☐	☐	
*If "YES," obtain pacemaker interrogation			
Congestive Heart Failure/ Fluid in lungs	☐	☐	
Palpitations/Irregular heartbeat	☐	☐	
Heart murmur	☐	☐	
Do you exercise	☐	☐	
How often? _____			
Type? _____			
Comments: _____			

PULMONARY	YES	NO	Year
Abnormal Chest X-ray	☐	☐	
Asthma	☐	☐	
Bronchitis	☐	☐	
Emphysema	☐	☐	
*Recent Respiratory Infection (within last 4 weeks)	☐	☐	
*Shortness of Breath with Exertion/Activity	☐	☐	
*Can you lay flat on your back	☐	☐	
Sleep Apnea	☐	☐	
☐ Snoring			
☐ Tired			
☐ Observed Stop Breathing			
☐ CPAP use at home			
Current Cough	☐	☐	
*Cough with mucous production	☐	☐	
Have you ever smoked	☐	☐	
How many years _____			
Pulmonary Embolism	☐	☐	
Oxygen/Ventilator Use	☐	☐	
Comments: _____			

HEMATOLOGIC/ONCOLOGIC/ INFECTIOUS	YES	NO	Year
Anemia	☐	☐	
Sickle Cell disease	☐	☐	
Blood clots in legs or lungs	☐	☐	
HIV	☐	☐	
History of Cancer	☐	☐	
If Yes, Type of Cancer _____			
Location _____			
Chemotherapy	☐	☐	
When _____			
Type _____			
Radiation therapy	☐	☐	

GASTROINTESTINAL	YES	NO	Year
Alcoholic liver disease	☐	☐	
Acid Reflux	☐	☐	
Heartburn	☐	☐	
Hepatitis	☐	☐	
Jaundice	☐	☐	
Alcohol use	☐	☐	
Amount: _____			
Recreational drugs	☐	☐	

URINARY/REPRODUCTIVE	YES	NO	Year
Urinary/Kidney disease	☐	☐	
*Dialysis	☐	☐	
*Hemodialysis	☐	☐	
*Peritoneal Dialysis	☐	☐	
If Female, could you be pregnant	☐	☐	
Date of last menstrual period: _____			

NEUROMUSCULAR DISEASE	YES	NO	Year
ALS	☐	☐	
Muscular Dystropy	☐	☐	
Multiple Sclerosis	☐	☐	
Parkinsons	☐	☐	
Guillain - Barre	☐	☐	
Other	☐	☐	

ENDOCRINE	YES	NO	Year
Diabetes	☐	☐	
Thyroid Disease	☐	☐	
Taken Steroids in the past year	☐	☐	
Comments: _____			

MUSCULOSKELETAL	YES	NO	Year
Arthritis	☐	☐	
Rheumatoid	☐	☐	
Neck, Back Arm, Leg Problems?	☐	☐	
Herniated disc	☐	☐	
Comments: _____			

NEUROPSYCHIATRY	YES	NO	Year
*Stroke	☐	☐	
Seizure	☐	☐	
Fainting	☐	☐	
Dizziness	☐	☐	
Headache	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Psychiatric Care	☐	☐	
Comments: _____			

FOR PEDIATRIC PATIENTS ONLY

	YES	NO
Was child born prematurely	☐	☐
If YES, how many weeks premature were they _____		
Problems noted at birth	☐	☐
If YES, please explain: _____		

PRIOR SURGERY

Surgery: _____ Date
Complications:

Surgery: _____ Date
Complications:

Surgery: _____ Date
Complications:

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Please complete Page 1

UC Irvine Health

PREOPERATIVE ANESTHESIA SCREENING

Please provide the following information so we may contact your other physicians if necessary:

Primary MD Name: _____ Phone No: _____ Address: _____

Cardiologist Name: _____ Phone No: _____ Address: _____

Other Provider Name: _____ Phone No: _____ Address: _____

Patient Questionnaire

1. **Do you have any personal history of anesthetic complications** YES NO
   If YES, please explain: _____
2. Is there a family history of anesthetic complications YES NO
   If YES, please explain: _____

BLOOD

1. Do you have any reason why you would refuse blood or blood products YES NO
   If YES, please explain: _____
2. Do you have an Advance Directive YES NO
   If YES, please explain: _____

Bleeding Questionnaire (Yes/No marked on order) **(POSITIVE = ONE YES)**

YES	NO	
		Have you had abnormal bleeding following: Dental extractions? Major/minor operations? Major/minor injuries?
		Do you have trouble with any of the following: Easy bruising (bigger than 2 inches)? Frequent nose bleeds? Abnormal heavy menstrual periods? Bleeding into joints or muscles? Oozing a long time from cuts or scrapes?
		Have you ever needed a blood transfusion for unexpected or heavy bleeding after a surgical procedure?
		Is there any family history of abnormal bleeding?
		Do you currently take any sort of anticoagulant (blood thinner) medication? (Coumadin, Lovenox, Pradaxa, etc.)

MEDICATIONS (include over-the-counter and herbal)	Dose	Frequency
☐ I do not take medication		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
Office Staff: Medications Updated In Quest on:		

Allergies (list all)	Reaction
☐ I do not take medication	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

Do you have any **comments or concerns** you would like to share with our staff? YES NO
You may receive a phone call from the Anesthesia Department based on your medical history.

_____

_____

_____

PATIENT or GUARDIAN (PRINT NAME): SIGNATURE X DATE

OFFICE USE ONLY

QUESTIONNAIRE REVIEWED BY: NAME/TITLE: DATE:

Please complete BOTH pages

UCI Medical Center

OUTPATIENT PROCEDURE H & P SHORT FORM

Date: _____ Time: _____

PATIENT IDENTIFICATION

Indication(s) for Procedure and Treatment Plan:

History of Present Illness: Review of Symptoms

Previous Procedure:

Past Medical History/Social History	Medications	Allergies

Physical Examination:
VS: BP ____ HR ____ RR ____ T ____ AGE ____ WT ____ HT ____
HEENT: _____
CV: _____
LUNGS: _____
ABD: _____
EXTREMITIES: _____ PULSES: _____
BREAST EXAM: _____ RECTAL: _____
NEURO: _____ PELVIC: _____

Labs:
Na ___ Mg ___ CL ___ Ca ___ K ___ HCO3 ___ CRT ___ GLU ___ UA ___
BUN ___ PT ___ PTT ___ ACT ___ WBC ___ H/H ___ PLT ___ BHCG ___

EKG: _____
CXR: _____
Plan for Anesthesia/Sedation: _____
Informed Consent Obtained: ☐ YES ☐ NO

_____ MD
Physician Signature

Beeper #: _____

_____ MD
Printed Name

_____
Signature Title

Anesthesia Fax: 456-8794 Anesthesia Phone: 456-[illegible]

Patient Label

UC Irvine Health

CONSENT FOR OPERATION/PROCEDURES OR RENDERING OF OTHER MEDICAL SERVICES

1. I hereby authorize and direct _____ M.D. to perform the following operations or medical procedures upon the patient named above:

_____
Name or description of operation(s) or procedure(s)

_____

_____

_____

_____

2. I hereby authorize and direct the above named surgeon to provide or arrange for the provisions of such additional services as he/she or they may deem necessary or advisable, including but not limited to the administration and maintenance of anesthesia and the performance of services involving pathology and radiology, and I hereby consent thereto.

3. The University *of* California, Irvine Healthcare is a research institution. I understand that any data or specimen(s) obtained during any examination, treatment, or procedure, including any laboratory or surgical procedure, of the patient may be used in research which may or may not be related to the patient's treatment or condition. Specimen means and includes, without limitation, any organ, tissue, bone or other bodily fluids of any kind. I further understand that the patient has no property or ownership interest in such specimen(s) or data and no right or entitlement in any research or research product using or derived from the specimen(s). I further authorize the pathologist to use his/her discretion in the disposition or use of any member, organ, or other tissue removed from my person during the operation(s) or procedure(s) identified above.

4. My physician does not have any independent financial or research interest in the procedure/treatment, other than usual or customary, unless checked below.
☐ My physician has informed me he/she does have independent financial or research interest in this procedure/treatment.

5. I understand that there may be a healthcare industry manufacturer's representative present during the procedure/treatment and I consent to this, at the discretion and approval of my physician and hospital, unless checked below.
☐ I do not consent to the presence of any healthcare industry manufacturer's representative.

6. The University *of* California is a teaching institution, I understand that Fellows and Residents, acting under the supervision of the primary surgeon/practitioner, may be performing important procedural tasks related to this surgery or procedure in accordance with hospital policy and based upon their skill set. These tasks may include but are not limited to: opening/closing, harvesting grafts, dissecting tissue, removing tissue, transplanting tissue, implanting devices and placing monitoring or invasive lines.
☐ I also understand that qualified medical practitioners, who are not physicians (e.g. Physician's Assistants), may also be performing important procedural tasks that are within their scope of practice as determined by California state law and regulation and for which they have been granted privileges by the University *of* California, Irvine Healthcare.

The nature and purpose of the operation or medical procedure has been explained by a member of the procedure team. The risks, complications, and expected benefits of such operation and/or medical procedure and/or sedation (if applicable) have also been explained. The therapeutic alternatives to the operation and/or medical procedure and/or sedation (if applicable) and their risks and benefits have been explained. No warranty or guarantee has been made as to the result or cure.

Signature of Patient/Patient's Representative _____ Date _____ Time _____

Relationship of Representative to Patient _____

Resident Physician Providing Information (Signature) _____ M.D. _____ Date

Resident Physician Providing Information (Printed Name) _____

Signature of Witness or Interpreter _____ Date _____ Time _____

Attending Physician (Signature) _____ M.D. _____ Date _____ Time

Attending Physician (Printed Name) _____

1. If the patient is a MINOR, the parent or guardian must sign as "Patient's Representative" unless the patient is legally permitted to sign.

2. If the patient is LEGALLY INCOMPETENT, the court approved guardian or conservator must sign as the "Patient's Representative"

3. If the patient reads no English, Spanish, or Vietnamese, an interpreter shall read this form to the patient. The patient and the interpreter shall sign at the end of Section II and the interpreter shall indicate the language used: _____

4. If the patient is PHYSICALLY INCAPABLE OF SIGNING, then:
   a. If the patient can make a mark, the patient should do so, witnessed by a University employee, or
   b. If the patient is physically incapable of signing, a University employee, and when possible, the patient's spo or next of kin, should sign in witness of the patient's having given verbal consent.

   In either case, an Employee-Witness or interpreter will sign as Witness and write in the reason in the space provided: _____

5. If the person having legal capacity to consent for the patient is not otherwise available, consent for medical or surgica treatment has been obtained by telephone. Note (telephonic) next to patient's representative's name.

6. THIS IS AN EMERGENCY. _____, M.D.