

PRE-PROCEDURE ORDER FORM GUIDELINES

PURPOSE: Standardize the ordering guidelines for our proceduralist's offices and assist with accurate and complete pre-procedural testing to avoid delay of care. Please have patient complete all pre-procedural testing and consultations as early as possible. If patient has not had labs at time of PAT appointment, PAT will attempt to coordinate with the patient to have labs drawn. Please submit orders upon scheduling the case. This order is not a scheduling reservation form.

I. DEMOGRAPHICS:

Required fields:

- **Patient name, DOB, home phone** & cell phone if applicable.
- **Facility, date of procedure, Start time, length** (Min)
- **Anesthesia Type.** "Other" can be used to indicate the other anesthesia type requested.
- **Primary proceduralist**, please include full name.
- **Patient allergies**
- **Patient Status**
- **Consent to read.** Please write/type full consent for procedure with no abbreviations. Consent should match what patient is signing and agreeing for their procedure.

II. PRE-PROCEDURAL ORDERS FOR PROCEDURE:

1. LABS:

- Please indicate any lab work the patient will need to have done before procedure within a HonorHealth outpatient lab, or day of procedure in department. PAT will coordinate with the patient to have labs drawn prior to procedure whenever possible. Patients having labs drawn at an outside facility such as PCP, Sonora Quest, LabCorp do not need labs indicated on the order form.
- If any labs are needed other than what is listed, please use the "other" box to indicate labs needed.

2. TESTS:

- Please indicate any testing patient will need to have done before procedure within HonorHealth or day of procedure in department. PAT will coordinate with patient to have any EKG prior to procedure whenever possible. Patient needing more detailed testing such as MRI, Nuclear Medicine, Ultrasound, and Interventional Radiology (IR) will need to be coordinated by the proceduralists' office with the patient. Patients having testing done at an outside facility such as PCP, SMIL, SimonMed, do not need testing indicated on order form.
- If any testing is needed other than what is listed, please use the "other" box to indicate testing needed. This includes any other department such as Ultrasound, Interventional Radiology (IR), or Nuclear Medicine that's needed for your procedural case.

3. BLOOD GLUCOSE TESTING:

- **Per HonorHealth Protocol: All HonorHealth locations glucose test every patient for Diabetes or elevated blood glucose day of procedure. This protocol provides the Pre-procedural RN with the medications to treat elevated glucose and notify necessary providers of the glucose values.**

4. MEDICATIONS:

- **Prophylactic Antibiotics; If no antibiotics are needed for the procedure, please indicate "none."**
- **Pre-Procedure Medications.** If the patient needs medications other than antibiotics in department, please indicate here.

5. LINES:

1. **Preselected Intravenous (IV) Fluids.** Procedural patients have an IV inserted day of procedure with IV fluids per HonorHealth patient care policy.
2. **Lidocaine** can be used by the department RN to numb the IV insertion site, please indicate if wanting this option available for patient.
3. **Port-A-Cath** can be used by the department RN to provide IV fluids per HonorHealth patient care policy.

6. BRONCHOSCOPY/LARYNGOSCOPY

- **Consider Airborne Isolation for the following:** Upper Lobe Cavitory Lesion, Millitary Nodular Disease, Non Resolving Pneumonia, Recurring Pulmonary Infection, Emigration from TB Epidemic area, Positive Skin or Serologic Testing for TB, Recent Exposure to TB, Persistent Pneumonia, Hemoptysis, and/or History of TB.
- Select type of endscope needed for procedure.
- Select fluroscopy if needed for procedure.
- If Additional oral anesthetics are needed for procedure please indicate here.

III. C-ARM Required:

- Please indicate weather or not your patient needs to have a C-ARM available for procedure.

IV. VENDORS/SPECIAL NEEDS:

- Please indicate here if any special equipment or vendors that will be needed in the procedure room.

V. VOID ON CALL TO PROCEDURE:

- As a standard of care, all patients will use the restroom to void before going to the procedure room.

VI. PLEASE PRINT FOR PHYSICIAN SIGNATURE.

Please Fax Orders to:

All future case orders are to be faxed upon scheduling to:

| 480-882-7874

If the case is scheduled for anything earlier than two days out, please fax directly to facility:

Osborn Pre-admission Testing:

| 480-882-6885

Shea Pre-admission Testing:

| 480-323-3287

Piper Pre-admission Testing:

| 480-323-3946

Thompson Peak Pre-admission Testing:

| 480-882-5836

John C. Lincoln North Mountain Pre-admission Testing:

| 602-870-6090

Deer Valley Pre-admission Testing:

| 623-879-5821

Patient Name: _____ DOB: _____ H: _____ C: _____

Facility _____ Date of Procedure _____ Start Time _____ Length (Min) _____

Anesthesia Type: General MD Sedation Other: _____

Primary Proceduralist: _____

Patient Allergies? NKDA Yes: Latex Other _____

Pt Status: Inpatient Outpatient **Post OP Bed?** No Yes ICU **Length of stay?** _____

CONSENT TO READ(NO ABBREVIATIONS)

PRE-PROCEDURE ORDERS

Please check boxes for clarity.

1. LABS:

- UA BMP CBC CBC/Diff PT/INR PTT H&H ISTAT
 POCT Urine Preg (per HH Protocol) BHCG Qualitative (blood) BHCGUA (Urine) Urine, C&S if indicated Comp Metabolic Panel
 Type and Screen Type & Crossmatch _____ units of PRBCs Other: _____

2. TESTS:

- EKG
 Other: _____

3. BLOOD GLUCOSE TESTING: per HonorHealth Protocol

4. MEDICATIONS: *To ensure appropriate dosage, please provide patient height and weight* Height _____ FT _____ IN Weight _____ LBS

1. Prophylactic Antibiotics _____
 2. Pre-Procedure Medications: _____

5. LINES

3. Start IV 1000 mLs LR @ to keep open (Substitute 0.9% NaCl for Diabetes and Renal Disease) Other: _____
 May use Lidocaine 1% .5 mL intradermal PRN for IV insertion
 May access Port-A-Cath PRN

6. BRONCHOSCOPY/LARYNGOSCOPY

- a. Isolation / Precautions: No Yes ; if Yes, what type: _____
 b. Flexible Endoscope: Disposable Reusable Therapeutic Other: _____
 c. Fluoroscopy: With Without

Five minutes prior to procedure administer:

- Spray throat with oral anesthetic TOPEX Gargle with _____ ml of _____ % Lidocaine

Lidocaine Viscous (Xylocaine) 2% solution _____

SVN of: _____ Other: _____

C-ARM NEEDED? Yes No

VENDORS/SPECIAL NEEDS:

VOID ON CALL TO PROCEDURE

Above orders may include Anesthesia recommendations

Physician Signature: _____

Print Physician Name: _____

Date: _____

Time: _____

GENERIC INTERCHANGE AND AUTOMATIC THERAPEUTIC INTERCHANGE FOR SPECIFIC DRUGS AS APPROVED BY THE MEDICAL STAFF ARE PERMITTED

KEY:

C/R- COMPUTER/REQUISITION
 MAR- MEDICATION RECORD
 ✓ - KARDEX NOTATED

Chart / Media

Physician Orders