

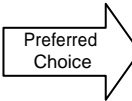
McLaren Flint
Gynecology Surgery
Pre-Operative Admission Order Set

Surgeon _____ Date of Surgery _____
 Name of Patient _____ Date of Birth _____
 Procedure _____
 Primary Care Physician _____ Allergies _____
 Consult _____ Consult _____
 Weight (Kg) (required) _____ Height (Cm) (required) _____

- IN PRE-OP:** 2% Chlorhexidine cloths apply chin to toes (including back) *Except Mucous Membranes*
- Apply Bair Paws Gown
- Glucometer in Pre-op

MEDICATIONS: Administer if not allergic

PROPHYLACTIC ANTIBIOTICS:



- Cefazolin (KEFZOL) IVPB and Metronidazole (FLAGYL) IVPB** -- Administer within one hour of surgical incision
 If Patient weights < 50 kg, **Cefazolin (KEFZOL) 1 gram IVPB** and **Metronidazole (FLAGYL) 500 mg IVPB**
 If Patient weighs 50-120 kg, **Cefazolin (KEFZOL) 2 grams IVPB** and **Metronidazole (FLAGYL) 500 mg IVPB**
 If Patient weighs ≥120 kg, **Cefazolin (KEFZOL) 3 grams IVPB** and **Metronidazole (FLAGYL) 500 mg IVPB**
 -- Redose **Cefazolin (KEFZOL) per above dose IVPB** intraoperatively every 4 hours for CrCl ≥ 30 mL/min;
 every 6 hours for CrCl 10-29 mL/min; do not redose for CrCl < 10 mL/min
 -- Redose **Metronidazole (FLAGYL) 500 mg IVPB** intraoperatively after 6 hours

ONLY IF life-threatening angioedema or anaphylaxis to cephalosporin or penicillin,

- Clindamycin (CLEOCIN) 600 mg IVPB** -- Administer within one hour of surgical incision
 --Redose **Clindamycin (CLEOCIN) 600 mg IVPB** intraoperatively after 6 hours
AND
Gentamicin 5 mg/kg (max 500 mg) IVPB -- Administer within one hour of surgical incision

OR

- Metronidazole (FLAGYL) 500 mg IVPB** -- Administer within one hour of surgical incision
 --Redose **Metronidazole (FLAGYL) 500 mg IVPB** intraoperatively after 6 hours
AND
Gentamicin 5 mg/kg (max 500 mg) -- Administer within one hour of surgical incision

VTE PROPHYLAXIS:

- Heparin 5000 units Subcut x 1 dose @ _____ am / pm
- Apply and Turn **ON** Sequential Pneumatic Compression (SCD) Device **PRIOR TO INDUCTION OF ANESTHESIA**

LABS DAY OF SURGERY: CBC BMP CMP PT/PTT/INR T&S _____ _____
 Urine Pregnancy Test (*if less than 50 years old with intact uterus only*) _____

OTHER ORDERS: _____

Physician Signature _____ Date (required) _____ Time (required) _____

Email all orders to PAT@mcclaren.org or FAX to PAT at 810-342-2353

PHYSICIANS ORDERS AND INSTRUCTIONS TO NURSING

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PT. MR.#/P DR.	
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