

DANGEROUS/UNACCEPTABLE ABBREVIATIONS - DO NOT USE

QD QOD U IU MS MSO4 MgSO4 Trailing Zero Lack of leading Zero

*****ALL PRN MEDICATIONS ORDERED MUST HAVE A REASON ******

| | | |
|---------------------|---------------------|--------------------------|
| Date Ordered | Time Ordered | PHYSICIAN'S ORDER |
|---------------------|---------------------|--------------------------|

6. Labs (continued)

- | | | | |
|--|---|-------------------------------------|--|
| <input type="checkbox"/> CBC with platelets/Diff | <input type="checkbox"/> CRP | <input type="checkbox"/> Free T3 | <input type="checkbox"/> Testosterone |
| <input type="checkbox"/> Basic metabolic panel | <input type="checkbox"/> Transferrin | <input type="checkbox"/> Free T4 | <input type="checkbox"/> B-HCG Quant |
| <input type="checkbox"/> Comprehensive metabolic panel | <input type="checkbox"/> PTH | <input type="checkbox"/> Serum T3 | <input type="checkbox"/> Urine toxicology |
| <input type="checkbox"/> Liver function profile | <input type="checkbox"/> PTH-rp | <input type="checkbox"/> Serum T4 | <input type="checkbox"/> UA/reflex culture (choose indication) |
| <input type="checkbox"/> PT/INR | <input type="checkbox"/> Vitamin D 25 Hydroxy | <input type="checkbox"/> Prealbumin | <input type="checkbox"/> Urology patient <input type="checkbox"/> CVA tender |
| <input type="checkbox"/> PTT | <input type="checkbox"/> Calcitonin | <input type="checkbox"/> HgbA1c | <input type="checkbox"/> Dysuria <input type="checkbox"/> Urinary frequency |
| <input type="checkbox"/> Platelet Function Assay | <input type="checkbox"/> Calcium | <input type="checkbox"/> PSA | <input type="checkbox"/> Suprapubic pain <input type="checkbox"/> Fever |
| <input type="checkbox"/> Potassium | <input type="checkbox"/> TSH | <input type="checkbox"/> AFP | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sed rate | | <input type="checkbox"/> CEA | |
| <input type="checkbox"/> Other _____ | | | |

7. Diet:

- ESR (Early Surgical Recovery) Patients** NPO After Midnight Except Medications and clear liquids; May have clear liquids up to arrival to the hospital (**Beverages and instructions to dispensed patient in Pre-admission testing unit per protocol**)
Most patients will qualify, exclude patients if high aspiration risk e.g. bowel obstruction or non-functioning GI tract
- NON-ESR (Early Surgical Recovery) Patients** NPO Past MIDNIGHT Except meds only
*** this only includes patients who do not qualify for ESR based on above recommendations***
- All patients:** NPO except meds after arrival to the hospital

8. Vitals per routine (including pulse ox)

9. Nursing Care in Outpatient Surgery:

- CHG Bath -> Comments: Cloths for pre-op scrub of surgical site on admission
- Hair removal -> Comments: Clip hair in area of surgical site in Outpatient Surgery room

10. IV fluids

- Lactated ringers solution 1000ml IV ON CALL**

11. VTE Prophylaxis:

- Apply Sequential Compression Device
- Administer in Outpatient Surgery** (select based on hospital guidelines)
(Do not administer in patients receiving epidural block, please verify with anesthesiologist)
 - HEPARIN SODIUM PORCINE 5000 UNIT SUBQ ON CALL**
 - HEPARIN SODIUM PORCINE 7500 UNIT SUBQ ON CALL (Consider if BMI ≥40kg/m²)**
 - Enoxaparin 40mg SUBQ ON CALL**
 - Other (Dispense as written) _____

| | | | |
|-----------------------|-------------|-------------------|-------------|
| Physician's Signature | Date & Time | Nurse's Signature | Date & Time |
|-----------------------|-------------|-------------------|-------------|

| | | |
|--------------------------|--------------------|-------------|
| Physician's Printed Name | Nurse's Print Name | Date & Time |
|--------------------------|--------------------|-------------|

DO NOT USE FORM AFTER THE ORDERS HAVE BEEN SIGNED AND FAXED/SCANNED

TULANE HEALTH
SYSTEMS

Affix Patient ID Label Here

ESR Preoperative Order Set

Patient Name: _____

M.R.# _____



DANGEROUS/UNACCEPTABLE ABBREVIATIONS - DO NOT USE

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Date Ordered Time Ordered PHYSICIAN'S ORDER

12. Outpatient Surgery Medications

- Administer oral medications with small sip of water in Outpatient Surgery
- If the patient cannot tolerate pills by mouth: convert PO meds to liquid version if available
- Scopolamine** Transdermal patch 1.5mg (apply behind ear in Outpatient Surgery prior to surgery)
(Contraindicated in patients with narrow angle glaucoma, elevated intraocular pressure, & age >65 years)
- Acetaminophen** 1000mg PO x1 ON CALL (consider reduced or avoided dose with liver failure)
- Gabapentin** 600mg PO x1 ON CALL (For patients <60 years old/ serum Cr <1.5 mg/dl)
- Gabapentin** 300mg PO x1 ON CALL (For patients ≥60 & <70 years old / serum Cr ≥1.5 mg/dl)
- Gabapentin** 100mg PO X1 ON CALL (Consider in patients ≥70 years old)
- Celecoxib** 400mg PO x1 ON CALL (For patients <60 years old/ serum Cr <1.5 mg/dl)
- Celecoxib** 200mg PO x1 ON CALL (For patients ≥60 years old/ serum Cr ≥1.5 mg/dl)
- Methylnaltrexone** 12mg SUBQ ON CALL (Decrease dose if patient <60kg and/or Cr≥1.5mg/dl)
- Other** (Dispense as written)_____

13. Antibiotic Prophylaxis: (SEND ON CALL TO OR) Administer antibiotics pre-op x1 dose within 1 hour of incision (except vancomycin, ciprofloxacin, levofloxacin and fluconazole that are given between 60-120 minutes prior to incision)

******SEE FINAL PAGE OF ORDERSET FOR ANTIBIOTIC GUIDELINES******

- Other antibiotics (Dispense as written)_____

- | | |
|--|---|
| <input type="checkbox"/> Cefazolin 2 grams IV (weight < 120kg) on call | <input type="checkbox"/> Aztreonam 2 gram IV on call |
| <input type="checkbox"/> Cefazolin 3 grams IV (weight ≥ 120kg) on call | <input type="checkbox"/> Ciprofloxacin 400mg IV on call |
| <input type="checkbox"/> Cefoxitin 2 grams IV on call | <input type="checkbox"/> Clindamycin 900mg IV on call |
| <input type="checkbox"/> Ampicillin 2 grams IV on call | <input type="checkbox"/> Gentamycin 5mg/kg IV on call |
| <input type="checkbox"/> Ampicillin/sulbactam 3 grams IV on call | <input type="checkbox"/> Gentamycin 80mg IV on call |
| <input type="checkbox"/> Ampicillin/sulbactam 1.5 grams (weight ≤ 80kg) IV on call | <input type="checkbox"/> Levofloxacin 500mg IV on call |
| <input type="checkbox"/> Piperacillin/tazobactam 3.375 gram IV on call | <input type="checkbox"/> Metronidazole 500mg IV on call |
| <input type="checkbox"/> Fluconazole 400mg IV on call | <input type="checkbox"/> Vancomycin 15mg/kg IV on call |

- Auto consult to pharmacy for dosing when IV Vancomycin or IV gentamycin ordered

Physician's Signature Date & Time Nurse's Signature Date & Time

Physician's Printed Name Nurse's Print Name Date & Time

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M.R.# _____



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*****ALL PRN MEDICATIONS ORDERED MUST HAVE A REASON ******

Date Ordered Time Ordered PHYSICIAN'S ORDER

14. Regional Block

- Consult anesthesiology for post-operative pain management (Regional block)

15. Local Anesthetic (on CALL TO OR)

- Bupivacaine 0.25% vial ON CALL to OR
- Bupivacaine 0.25% with epinephrine 1:200,00 vial ON CALL to OR
- Bupivacaine 0.5% vial ON CALL to OR
- Bupivacaine 0.5% with epinephrine 1:200,00 vial ON CALL to OR
- Other** (Dispense as written) _____

16. Miscellaneous orders

- Belladonna and opium suppository x1 ON CALL to OR
- _____
- _____
- _____

Best person to contact if there are problem with these orders:

NAME: _____ Contact number _____

STOP: TO avoids delays make sure the following have occurred

- The physician has signed every page**
- You included a surgery date**
- You included ICD codes**
- You included CPT codes**
- History and Physical in chart (<30 days before surgery)**

Physician's Signature Date & Time Nurse's Signature Date & Time

Physician's Printed Name Nurse's Print Name Date & Time

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Patient Name: _____

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PRE-OPERATIVE ANTIBIOTIC REFERENCE --- NO ORDERS ON THIS PAGE

| True drug allergy is based on the presence of a patient response with one or more of the following signs/symptoms: respiratory difficulty, hypotension, rash, or hives. In the absence of these findings, an antibiotic of the same classification may be used for surgical prophylaxis. | |
|--|--|
| Indication | Pre-op Antimicrobial & Dose |
| Abdominal: Esophageal, Bariatrics; Gastroduodenal; Biliary non infected; Gynecological: C-section [administer within 60 minutes prior to incision); <i>before</i> cord clamping] | Cefazolin 2 g (3g if >120 kg) IV x 1 dose Allergy: clindamycin 900mg IV + gentamicin 5 mg/kg IV x 1 dose |
| Abdominal: appendectomy, biliary infection, colorectal surgery of any type, whipple or small bowel | Colorectal prep: neomycin sulfate 1 g + erythromycin base 1g PO at 19, 18, & 9 hours prior to surgery (home therapy) + cefoxitin 2 g IV x 1 dose Allergy: metronidazole 500 mg IV + gentamicin 5 mg/kg IV x 1 dose |
| General: any implanted foreign body; hernia repair; PEG tubes; Head & Neck: clean procedures; Plastic Surgery | Cefazolin 2 g (3 g if >120 kg) IV x 1 dose Allergy: clindamycin 900mg IV x 1 dose |
| Cardiac: coronary artery bypass graft (CABG) +/- valve implant, pacemaker & other implants | Cefazolin 2 g (3g if >120 kg) IV x 1 dose Allergy: vancomycin 15 mg/kg IV + gentamicin 5 mg/kg IV x 1 dose MRSA concern: vancomycin 15 mg/kg IV + cefazolin 2 g (3 g if >120 kg) IV x 1 dose Allergy: vancomycin 15 mg/kg IV + gentamicin 5 mg/kg IV x 1 dose |
| Cardiac: pacemaker, defibrillator, ventricular assist device, & other implanted device | Cefazolin 2 g (3g if >120 kg) IV x 1 dose Allergy: clindamycin 900mg IV x 1 dose Allergy: vancomycin 15 mg/kg IV x 1 dose |
| Gynecological: all hysterectomy Synthetic pubovaginal sling | cefoxitin 2 g IV x 1 dose Allergy: Clindamycin 900 mg IV + gentamicin 5 mg/kg IV x 1 dose |
| Head & Neck Clean-contaminated procedures (oropharyngeal mucosa is compromised) | Ampicillin/sulbactam 3g (1.5g if less than 80kg) IV x 1 dose Allergy: clindamycin 900 mg IV x 1 |
| Neurosurgery: craniotomy, shunts, laminectomies, & spinal fusion; Thoracic: non-cardiac | Cefazolin 2 g (3 g if >120 kg) IV x 1 dose Allergy: vancomycin 15 mg/kg IV x 1 dose |
| Orthopedic: internal fixation of fracture & joint replacement (hip or knee), any implanted foreign body | Cefazolin 2 g (3 g if >120 kg) IV x 1 dose Allergy/MRSA concern: vancomycin 15mg/kg IV x 1 dose **complete infusion before tourniquet inflation** Gentamicin 5mg/kg IV x 1 dose (if gram negative concern) |
| Urologic: TURP only, otherwise <i>**indicated only for patients with known bacteriuria**</i> | Cefazolin 2g (3 g if >120 kg) IV x 1 dose If catheter in place: Ampicillin 2 grams IV q6h + Gentamicin 5 mg/kg IV once Allergy: clindamycin 900mg IV x 1 dose + gentamicin 5mg/kg IV x 1 dose |
| Urologic: transrectal biopsy | Gentamicin 80mg IV + Ciprofloxacin 400mg IV x1 cefoxitin 2g IV once |
| Urologic: Open/lap; cystoscopy with manipulation or upper tract instrumentation (lithotripsy, ureteroscopy) | Cefazolin 2 g (3 g if >120 kg) IV x 1 dose + gentamicin 5mg/kg IV x 1 dose Allergy: clindamycin 900mg IV + gentamicin 5mg/kg IV x 1 dose |
| Urologic: prosthetics, stents, penile prosthetics | Cefazolin 2 g (3 g if >120 kg) IV x 1 dose + gentamicin 5mg/kg IV x 1 dose Allergy: vancomycin 15mg/kg IV + gentamicin 5mg/kg IV x 1 dose |
| Vascular: amputation, arterial surgery, vascular access devices, implants, repair | Cefazolin 2 g (3 g if >120 kg) IV x 1 dose Allergy: vancomycin 15mg/kg IV + gentamicin 5mg/kg IV x 1 dose |

Effective 01/01/2016

MEDICARE ORDER FORM

DIAGNOSIS:

SCHEDULED PROCEDURE & DATE:

TWO MIDNIGHTS OR MORE

I expect the patient will require hospital care for TWO MIDNIGHTS OR MORE. (Documentation must be present in the medical record to support the expectation of two or more midnights.)

ADMIT TO INPATIENT STATUS

LESS THAN TWO MIDNIGHTS (Check only one status - either Inpatient or Outpatient)

I expect the patient will require hospital care for LESS THAN TWO MIDNIGHTS or I am uncertain as to the length of stay.

PLACE PATIENT IN OUTPATIENT STATUS

PLACE PATIENT IN OUTPATIENT STATUS and BEGIN OBSERVATION SERVICES

(Observation is a defined set of monitoring services that is typically ordered to evaluate a patient's condition for the purpose of determining whether the patient should be admitted as an inpatient or discharged.)

ADMIT TO INPATIENT STATUS (Documentation must be present in the medical record to support at least one of the following selections; check all that apply.)

Inpatient only procedure defined by CMS' Inpatient Only List

Patient is medically unstable and requires immediate medical intervention, as well as frequent monitoring and changes in treatment plan

Patient has significant risk factors that increase the probability of an adverse event if not monitored closely for an extended time period

Patient requires active clinical monitoring, diagnostic studies, procedures or treatment that cannot be completed safely in an outpatient setting

Patient failed to improve following outpatient treatment that necessitates further evaluation and treatment

TO BE VALID, THE ORDER MUST BE SIGNED, DATED AND TIMED BEFORE PATIENT DISCHARGE.

Telephone/Verbal Order per _____ Taken/Read Back by _____ Date/Time: _____
Admitting Physician Name (print) Signature/Credential

Resident Signature: _____ Date/Time: _____

Physician Signature: _____ Date/Time: _____

MEDICARE ORDER FORM S



MOS

01/01/16

PATIENT INFORMATION

LAST NAME:

FIRST NAME:

DOB:

PHYSICIAN:

DATE: _____ **SHORT STAY FORM**

History

Chief Complaint/Admit DX: _____

Present Illness: _____

Significant Findings: _____

Family Medical History: _____

Past Illness: _____

Past Operations: _____

Medications: _____

Allergies: _____

Social History: Alcohol _____ Tobacco _____ Other: _____
Mental History: Alert _____ Disoriented _____ Drowsy _____ Lethargic _____ Other _____
Immunization Record: (Pediatric): _____

PHYSICAL EXAMINATION: T _____

P _____ R _____ BP _____
General: _____ HEENT: _____ Heart: _____ Lungs: _____ Abdomen: _____ Neurological: _____
Other Body Systems (specific to procedure): _____ Impression: _____
Plan: _____

PHYSICIAN'S SIGNATURE: _____ DATE/TIME: _____

DISCHARGE SUMMARY:

Final Diagnosis: _____

Diet: _____ Regular _____ Soft _____ Liquid _____ Other: _____

Activities: _____

Condition of Pt on Discharge: _____ Ambulatory _____ Afebrile _____ Voiding _____ Vital Signs Stable

Medications: _____

Follow-up: _____

Additional Comments: _____

PHYSICIAN'S SIGNATURE: _____

DATE/TIME: _____

PHYSICIAN'S Printed Name: _____

Tulane Medical Center
1415 Tulane Ave.
New Orleans, LA



SHORT STAY FORM

Patient Consent to Medical Treatment or Surgical Procedure and Acknowledgement of Informed Consent

READ CAREFULLY BEFORE SIGNING

9. **Risks of no treatment:** _____

10. **Acknowledgment, Authorization, and Consent**

- (a) **No Guarantees:** I understand that all information given me, and in particular, all estimates as to risks and benefits of this or alternate procedures are made in my physician's best professional judgment. Complications cannot always be accurately anticipated and therefore, there is and can be no guarantee either expressed or implied, as to the success of the medical treatment or surgical procedure.
- (b) **Particular Concerns:** I have had an opportunity to discuss with my physician those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.
- (c) **Questions:** I have had an opportunity to ask my physician, and I have asked, any questions I may have about the information in this Consent Form and other questions I have about the proposed treatment or procedure and all such questions were answered satisfactorily.
- (d) **Authorized physician:** Physician (or physician group) responsible for treatment, procedure or therapy described in Item #2, is:

Printed Name: _____

(e) **Who will administer Anesthesia:** _____

- (f) Physicians other than the Authorized Physician (including but not limited to residents) will will not

be performing important tasks related to the surgery, under the supervision of the authorized physician, in accordance with the hospital's policies and the practitioner(s)' or resident(s)' availability and competence level. Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines. I am aware that the authorized physician may not be physically present in the same operating room for some or all of the surgical tasks performed by the resident(s).

- (g) **PHYSICIAN CERTIFICATION:** I hereby certify, to the best of my knowledge and ability, I have provided and explained the information contained in this Consent Form, including any attachments, and answered all questions of the patient or the patient's representative concerning the medical treatment, therapy or surgical procedure to be performed.

Signature of Physician: _____ **Date:** _____ **Time:** _____

Printed Name of Physician: _____

PATIENT'S CONSENT: I, the patient or the patient's representative, hereby authorize and direct the designated physician, together with associates, assistants, residents or qualified medical practitioners of my physician's choice, to administer or perform the medical treatment or surgical procedure described in Item #2 of this Consent Form. I also consent to any additional procedures or services as they may deem necessary or reasonable, including the administration of general or regional anesthesia, x-rays or other radiological services, laboratory services, and the disposal of tissue removed during a diagnostic or surgical procedure.

I have read and understand all information set forth in this document, including any attachments, and all blanks were filled in prior to my signing. This authorization for and consent to medical or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask my physician any questions I have about the contemplated medical treatment or surgical procedure described in Item #2 of this Consent Form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Signature of Patient or Person Date Time Signature of Witness Date Time
Authorized to Consent

Relationship to Patient (if signature is not patient's) Printed Name of Witness

Tulane Medical Center



Consent Medical Treatment or Surgical Procedure

Patient Consent to Medical Treatment or Surgical Procedure and Acknowledgement of Informed Consent

Transfusion of Blood and Blood Components - page 1 of 3

READ CAREFULLY BEFORE SIGNING

TO THE PATIENT: Your physician has recommended that you consider medical treatment/surgery. Louisiana law requires your physician to tell you (1) the nature of your condition; (2) the general nature of the medical treatment/surgery; (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor; (4) reasonable therapeutic alternatives and material risks associated with such alternatives; and (5) risks of no treatment.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. Your physician wants you to be as informed as possible. Please read each page of this form carefully. Ask about anything you do not understand and your physician will be pleased to explain.

1. **Patient Name:** _____

2. **Treatment/Procedure:** Transfusion of Blood and Blood Components _____

3. **Anesthesia to be used:** **GENERAL:** _____ **OTHER:** _____

4. **Description of the treatment/procedure:** _____

5. **Indications for treatment/procedure:** _____

6. **Anticipated Benefits of the Treatment/Procedure:** _____

7. **Material Risks of Treatment/Procedure:**

All medical or surgical treatment involves risks. Listed here and on the attached pages that relate to your specific treatment/procedure are risks associated with this treatment/procedure and anesthesia, including the likelihood of the risks, based on the available clinical evidence, as informed by the responsible physician's clinical judgment. Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding these risks.

a) Risks generally associated with any surgical treatment/procedure, including anesthesia are: **death, brain damage, disfiguring scars, quadriplegia (paralysis from neck down), paraplegia (paralysis from the waist down), the loss or loss of function of any organ or limb, infection, bleeding, and pain.**

b) Risks listed for your procedure by the Louisiana Medical Disclosure Panel: (1) Fever, (2) Transfusion reaction which may include kidney failure or anemia, (3) Heart failure, (4) Hepatitis, (5) AIDS (acquired immune deficiency syndrome), (6) Other infections.

_____ Risks determined by your physician: _____

c) Additional risks (if any) particular to the patient because of a complicating medical condition: _____

8. **Treatment alternatives including attendant risks and benefits:** _____

**Patient Consent to Medical Treatment or Surgical Procedure
and Acknowledgement of Informed Consent**

Transfusion of Blood and Blood Components - page 2 of 3

READ CAREFULLY BEFORE SIGNING

9. **Risks of no treatment:** _____

10. **Acknowledgment, Authorization, and Consent**

- (a) **No Guarantees:** I understand that all information given me, and in particular, all estimates as to risks and benefits of this or alternate procedures are made in my physician's best professional judgment. Complications cannot always be accurately anticipated and therefore, there is and can be no guarantee either expressed or implied, as to the success of the medical treatment or surgical procedure.
- (b) **Particular Concerns:** I have had an opportunity to discuss with my physician those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.
- (c) **Questions:** I have had an opportunity to ask my physician, and I have asked, any questions I may have about the information in this Consent Form and other questions I have about the proposed treatment or procedure and all such questions were answered satisfactorily.
- (d) **Authorized physician:** Physician (or physician group) responsible for treatment, procedure or therapy described in Item #2, is:

Printed Name: _____

(e) **Who will administer Anesthesia:** _____

- (f) Physicians other than the Authorized Physician (including but not limited to residents) will will not
be performing important tasks related to the surgery, under the supervision of the authorized physician, in accordance with the hospital's policies and the practitioner(s)' or resident(s)' availability and competence level. Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines. I am aware that the authorized physician may not be physically present in the same operating room for some or all of the surgical tasks performed by the resident(s).

- (g) **PHYSICIAN CERTIFICATION:** I hereby certify, to the best of my knowledge and ability, I have provided and explained the information contained in this Consent Form, including any attachments, and answered all questions of the patient or the patient's representative concerning the medical treatment, therapy or surgical procedure to be performed.

Signature of Physician: _____ **Date:** _____ **Time:** _____

Printed Name of Physician: _____

PATIENT'S CONSENT: I, the patient or the patient's representative, hereby authorize and direct the designated physician, together with associates, assistants, residents or qualified medical practitioners of my physician's choice, to administer or perform the medical treatment or surgical procedure described in Item #2 of this Consent Form. I also consent to any additional procedures or services as they may deem necessary or reasonable, including the administration of general or regional anesthesia, x-rays or other radiological services, laboratory services, and the disposal of tissue removed during a diagnostic or surgical procedure.

I have read and understand all information set forth in this document, including any attachments, and all blanks were filled in prior to my signing. This authorization for and consent to medical or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask my physician any questions I have about the contemplated medical treatment or surgical procedure described in Item #2 of this Consent Form, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Signature of Patient or Person
Authorized to Consent

Date Time

Signature of Witness Date Time

Relationship to Patient (if signature is not patient's)

Printed Name of Witness

**Patient Consent to Medical Treatment or Surgical Procedure
and Acknowledgement of Informed Consent**

Transfusion of Blood and Blood Components - page 3 of 3

READ CAREFULLY BEFORE SIGNING

Informed Consent- Transfusion of Blood and Blood Components

Patient Instruction sheet- Not part of the medical record

WHAT IS A BLOOD TRANSFUSION

You may need to receive blood in order to stabilize your condition or to save your life. The type of transfusion and amount of blood that is given to you is a decision your physician will make based on your individual needs. Blood transfusions are given to replace the part of the blood that is missing. If you are anemic, your red blood cell level is lower than the level needed to carry adequate oxygen to the cells in your body. The transfusion given to correct anemia contains red blood cells. If you have a low platelet count and are at risk for bleeding, the component given to you is a platelet concentrate. Plasma or Cryoprecipitate are given to manage clotting problems.

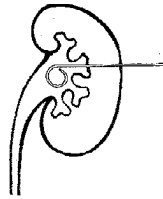
WHAT ARE THE SIDE AFFECTS

Most transfusions proceed without incident. Occasionally, problems arise. You may feel a cold sensation, due to the cool temperature of the blood. Sometimes, fever, chills and hives can occur, which are usually not significant. Rarely, more serious problems, such as infection, shortness of breath, back or chest pain, nausea, vomiting, fainting, or confusion may occur. If you have any of these symptoms during or after the transfusion, immediately call your Nurse or Doctor for assistance. If you have bleeding from the infusion site, you or your Nurse should apply firm pressure directly to the area until the bleeding stops.

Delayed reactions may occur days to weeks after a transfusion. Any changes in your general health such as unusual tiredness, change in appetite, unplanned weight loss, kidney failure, dark urine, yellowing eyes or skin (jaundice), swollen glands or heavy sweating at night should be immediately reported to your Doctor.

**Tulane University
Tulane Medical Center**

PERCUTANEOUS NEPHROLITHOTOMY



PURPOSE

Percutaneous Nephrolithotomy (PCNL) provides patients with a safe and effective way to remove kidney stones using a minimally invasive technique. Kidney stones are formed in the urinary tract due to crystallization of chemical compounds in the urine. PCNL is a technique used to remove certain large stones in the kidney or upper ureter (the tube that drains urine from the kidney to the bladder).

GENERAL INFORMATION

This procedure has been used on many patients for the past 20 years, replacing the need for open surgery to remove kidney stones in a majority of patients. It has been accepted as a safe and reliable technique. Typically, the length of the surgery is 3-4 hours. The surgery is performed by making one small 1/2 inch incision in the back flank area. A tube is placed through the incision into the kidney under x-ray guidance. A small telescope is passed through the tube to see the stone and remove it. If necessary a laser or other device called a Lithotripter may be used to break the stone into small pieces to ease in the removal. This procedure has resulted in significantly less post-operative pain, a shorter hospital stay, and an earlier return to work and daily activities when compared to the open operation.

WHAT TO EXPECT *PRIOR TO THE PROCEDURE*

The Surgical Coordinator will arrange for your pre-admission testing. She will review the date and instructions with you.

Be sure to verify the campus where you are having surgery.

Tulane University Medical Center

Pre-Admission (3rd floor of Hospital)

1415 Tulane Avenue

New Orleans, LA 70112-2699

Tel: (504) 988-5800 or 800-988-5800

Fax: (504) 988-5393

If other arrangements for pre-admission testing have been made, these results need to be faxed **at least 7 days** prior to your surgery. See fax numbers above.

You will need to obtain a letter of medical clearance from your primary care doctor or cardiologist within a week of your surgery date. Your doctor will fax this letter to our Pre-Admission Testing Office. We suggest that you also try to bring a copy of this letter with you at the time of your admission.

To assure your safety to undergo the procedure, the following tests need to be performed:

- Physical exam
- EKG (electrocardiogram)
- CBC
- PT / PTT
- Comprehensive Metabolic Panel
- Urinalysis
- Urine culture and sensitivity



PREPARING FOR THE SURGERY

- Drink clear fluids for a 24-hour period prior to the date of your surgery (please see attachment 1, Clear Liquid Diet).
- Do not eat or drink anything after midnight the night before the surgery. Drink 1/2 bottle of Magnesium Citrate, which is a laxative (and can be purchased at your local pharmacy) the evening before your surgery.
- Aspirin, Motrin, Ibuprofen, Advil, Alka Seltzer, Vitamin E, Ticlid, Coumadin, Lovenox, Voltaren, Plavix and some other arthritis medications can cause bleeding and should be avoided one week prior to the date of surgery. Please contact your surgeon's office if you are unsure about which medications to stop prior to surgery. Do not stop any medication without contacting the prescribing doctor to get their approval.

- It is very important that your last urine culture was negative prior to having this procedure. Please call the physician's office at least one week before this procedure to confirm your urine culture results. If you suspect that you may have a urinary tract infection, please call the physician's office immediately

POTENTIAL RISKS AND COMPLICATIONS

Although this procedure has proven to be very safe, as in any surgical procedure there are risks and potential complications. Potential risks include:

- **Bleeding:** Blood loss during this procedure is possible and a transfusion is necessary in approximately <10% of patients. If you are interested in autologous blood transfusion (donating your own blood) you must make your surgeon aware.
- **Infection:** All patients are treated with antibiotics to decrease the chance of infection from occurring after surgery. If you develop any signs or symptoms of infection after the surgery including fever, drainage from the incision, urinary frequency/discomfort, pain (or anything that you may be concerned about) please contact us at once.
- **Tissue / Organ Injury:** Although uncommon, possible injury to surrounding tissue and organs including bowel, lung, vascular structures, spleen, liver, pancreas and gall bladder may occur requiring further surgery. Loss of kidney function is rare but is a potential risk. Scar tissue may also form in the kidney or ureter requiring further surgery.
- **Conversion to Open Surgery:** This surgical procedure may require conversion to the standard open operation if difficulty is encountered during the procedure. This will result in a larger open incision and possibly a longer recuperation period.
- **Failure to Remove the Stone:** There is a possibility that the stone may not be able to be removed due to its size or the location at the time of surgery. Alternative treatment may be required.

WHAT TO EXPECT *AFTER* THE SURGERY

Immediately after the procedure you will be taken to the recovery area and transferred to your hospital room once fully awake and your vital signs are stable.

- **Post Operative Pain:** Pain medication can be administered to you via Patient Controlled Analgesia or PCA (Whereby you as the patient control the administration of your own pain medication by pressing a button) or by an injection or pill given to you by the nursing staff. Your preference will be discussed with you ahead of time by an anesthesiologist.
- **Nephrostomy Tube:** You can expect to have a small narrow hollow tube coming out of your back to allow urine to drain from the kidney into a drainage bag. This drain usually remains in place for two days. There is a possibility that you will be discharged from the hospital with a nephrostomy tube.
- **Stent:** You may have a ureteral stent (a very thin, hollow tube) in place to promote drainage from the kidney to the bladder (the reservoir that holds urine).

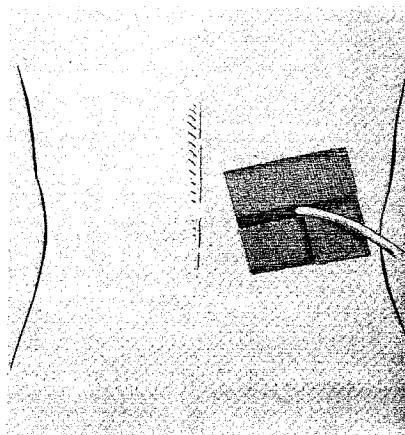
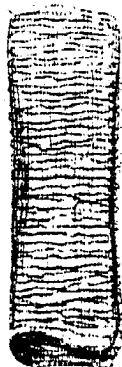
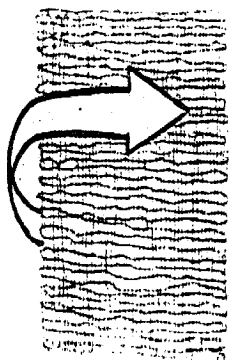
- **Nausea:** You may experience some nausea related to the anesthetic. Medication is available to treat persistent nausea.
- **Urinary Catheter:** You can expect to have a urinary catheter (a narrow hollow tube inserted into the urinary passage to drain your bladder) for approximately one day after surgery. It is not uncommon to have blood-tinged urine for several days after surgery.
- **Diet:** You can expect to have an intravenous catheter (IV) in for 1-2 days. (An IV is a small tube placed into your vein enabling you to receive necessary fluids and stay well hydrated until you are able to tolerate a diet; in addition it provides a way to receive medication). Most patients are able to tolerate ice chips and small sips of liquids on the first day and regular food by day two. Once on a regular diet, pain medication can be given by mouth instead of by IV or injection.
- **Fatigue:** Fatigue is common and should subside in a few weeks.
- **Incentive Spirometry:** You will be expected to do some very simple breathing exercises to help prevent respiratory infections through using an incentive spirometry device. (These exercises will be explained to you during your hospital stay). Coughing and deep breathing are an important part of your recuperation and help prevent pneumonia and other pulmonary complications.
- **Ambulation:** On the day of your procedure it is very important to get out of bed and begin walking with the supervision of your nurse or family member to help prevent blood clots from forming in your legs.
- **Hospital Stay:** The length of hospital stay for most patients is approximately one to two days.
- **Constipation:** You may experience sluggish bowels for several days or weeks. Suppositories and stool softeners are usually given to help with this problem. Taking mineral oil at home and eating plenty of fruits and vegetables will also help to prevent constipation.
- **Secondary Procedures:** Some patients have stones that are very large or that cannot be safely removed during the first procedure. You may need a "second look" to remove any remaining stone burden. This may be done during the current hospitalization or at another time.

WHAT TO EXPECT AFTER DISCHARGE FROM THE HOSPITAL

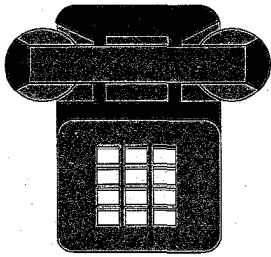


- **Pain Control:** You can expect to have some pain that may require pain medication for a few days after discharge, and then Tylenol should be sufficient to control your pain.
- **Activity:** Taking walks is advised. Prolonged sitting or lying in bed should be avoided. Climbing stairs is allowed. Driving should be avoided for at least 1-2 weeks after surgery. Activity can begin as tolerated. You can expect to return to work about two weeks after surgery or as instructed by your physician.
- **Follow-up Appointment:** Please call after your discharge to schedule a follow up visit for one week after your surgery date.
- **Stent follow up: If you have a stent in place, the** length of time the stent remains in place is variable. Your doctor will probably request it to be removed within a 2-6 week period. This can be removed in the doctor's office. It is common to feel a slight amount of flank fullness and urgency to void, which is caused by the stent. These symptoms often improve over time if the stent is left in place for a while.
- **Nephrostomy Site Care:** It is important that urine flow freely through the tube. Check daily to make sure the tube is not kinked. Make sure the stopcock, if present, remains in the open position to allow urine to drain. Keep the tube secure using folded 4x4 dressings around the tube, in a picture frame fashion (see diagram 1). Start with the folded gauze pad underneath the tube, for support and then continue around the tube with the folded sides facing the tube to support it. Place one 4x4 gauze pad on top and then secure the tape over this pad. Secure the tubing to your leg if open to drainage, leaving enough slack on the tube to prevent dislodgement of the tube upon movement. Monitor the amount of drainage, color and odor. Blood-tinged urine is not uncommon. Keep the drainage bag below the level of the kidney to promote gravity drainage. It is important to clean the area around the insertion site with hydrogen peroxide each day during your dressing change. You can shower with the dressing on, and then change it after the shower. You will need assistance in doing this dressing change.
- **Tubes open to drainage:** If you experience any pain, fever, chills, or lack of drainage from the tube while you are open to a drainage bag, contact your physician immediately. Some yellowish material around the tube is normal, as this is the body's reaction to the tube. If the drainage is foul-smelling or looks like "pus", contact your physician or nurse.

- **Clamped tubes:** If you experience any pain, fever, chills, or leakage around the tube, open your nephrostomy tube immediately to the drainage bag provided to you prior to leaving the hospital. If the urine drains, and the pain and fever subside, leave the tube to drainage and notify your physician or nurse. If the tube does not drain and your symptoms persist you may need to be seen on an urgent basis to have the tube flushed. Again, notify your physician or come to the emergency room. If there is any foul smelling drainage around the tube site, let us know, as this may be the sign of a local infection. Some drainage is normal.



CONTACTS



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In the event of a life threatening emergency contact 911 immediately; however, if and you need to contact someone in the evening hours or on the weekend, please call the page operator at (504) 988-5800 or 800-988-5800 and ask to speak to the Urologist on call.