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

1. Admit date: _____ Surgery date:_____ Pre-admit testing date:_____

2. **ADMIT/PATIENT STATUS ORDER**

   a. **ADMIT CAMPUS:** ☑ Downtown ☐ Lakeside

   b. **ADMIT Location:** ☑Med/Surg ❑NICU ❑CCU ❑SICU ❑NeuroICU ❑BMT ❑OBGYN ❑PEDI ❑TATU ❑PCU

   c. **INDICATE STATUS ORDER WITH A CHECKMARK:**

   ❑ Admit to inpatient status -> Estimated length of stay _____

   ❑ Place in outpatient status

   ❑ Place in Observation status and begin observation services

   Assign to Physician: _____ Service: Urology

   Diagnosis/Medical Necessity (Description/ICD code required):_____

   C61 Prostate Cancer

   Procedure(s) (Description/CPT code required):_____

   1. Laparoscopic Robotic-assisted Radical Prostatectomy

   2. Laparoscopic Robotic-assisted bilateral pelvic lymph node dissection

   If this is a combined case LIST SURGEON AND SERVICE LINE HERE: _____

3. **Drug Allergies:** nkda/other:

4. **Height _____cm Weight_____Kg**

5. **Xrays and other tests**

   ❑ **Chest xray (PA/LAT)** ❑ **EKG** ❑ **Other**_____

6. **Labs**

   ☑ ***Reminder: For diabetics only:*** Glucose Level, Bedside Frequency: Once on admission
   Comment: goal glucose < 180 mg/dL, if > 180 notify anesthesia

   ☑ **MRSA and MSSA screening per protocol in Pre-admission Testing**

   ❑ **Urine HCG (exceptions are previous hysterectomy or age >50 years with no menses for ≥ 2 years)**

   ❑ **Type and Screen**

   ❑ **Type and cross match __ units PRBC ON HOLD for OR (specify number of units)**

   ❑ **Type __ Units FFP ON HOLD for OR (specify number of units)**

   ❑ **__ Apheresis Platelets (equivalent to 5-6 pack of random donor platelets) ON HOLD for OR**

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 Preopeartive Order Set

Patient Name: _____

M.R.# _____

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)

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

❑ **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/m^2**)
❑ **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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*****ALL PRN MEDICATIONS ORDERED MUST HAVE A REASON ******

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)_____

_____

- ❑ Cefazolin 2 grams IV (weight < 120kg) on call
- ❑ Cefazolin 3 grams IV (weight ≥ 120kg) on call
- ❑ Cefoxitin 2 grams IV on call
- ❑ Ampicillin 2 grams IV on call
- ❑ Ampicillin/sulbactam 3 grams IV on call
- ❑ Ampicillin/sulbactam 1.5 grams (weight ≤ 80kg) IV on call
- ❑ Piperacillin/tazobactam 3.375 gram IV on call
- ❑ Fluconazole 400mg IV on call
- ❑ Aztreonam 2 gram IV on call
- ❑ Ciprofloxacin 400mg IV on call
- ❑ Clindamycin 900mg IV on call
- ❑ Gentamycin 5mg/kg IV on call
- ❑ Gentamycin 80mg IV on call
- ❑ Levofloxacin 500mg IV on call
- ❑ Metronidazole 500mg IV on call
- ❑ 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

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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*****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 504-213-1587

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

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

TULANE HEALTH SYSTEM

Affix Patient ID Label Here

ESR Preoperative Order Set

Patient Name: _____

M.R.# _____

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); *before* 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 ***indicated only for patients with known bacteriuria***	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:
C61 Prostate Cancer	

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: C61 Prostate Cancer

Present Illness: _____

Significant Findings: _____

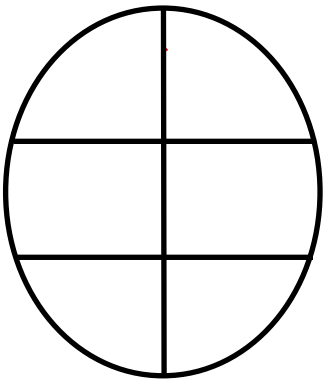
Family Medical History: _____

Past Illness:_____

Past Operations: _____

Medications: _____

Allergies: _____



Dx: Prostate Cancer

Plan: Robotic Prostatectomy

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

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

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: Robot Assisted Radical Prostatectomy; Bilateral Pelvic Lymphadenectomy

3. Anesthesia to be used: GENERAL: ☑ OTHER: ☐

4. Description of the treatment/procedure: Remove prostate cancer

5. Indications for treatment/procedure: Prostate Cancer

6. Anticipated Benefits of the Treatment/Procedure: Remove prostate cancer

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 , its recuperation, 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, disfi guring 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: Bleeding , Infection, Pain, Scarring, Need for further procedures; Damage to nearby blood vessels, nerves, bowels, abdominal organs

☑ Risks determined by your physician : Bleeding, infection, injury to adjacent organs such as bowel, rectum, ureter Urinary incontinence, erectile dysfunction, conversion to open procedure, bladder neck contracture, incisional hernia, paralytic ileus, urinary tract infections

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

8. Treatment alternatives including attendant risks and benefits: _____
Radiation therapy, active surveillance, open surgery

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

READ CAREFULLY BEFORE SIGNING

9. **Risks of no treatment:** Spread of prostate cancer outside the prostate

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: , MD

(e) **Who will administer Anesthesia:** Tulane 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: , MD

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

Tulane Medical Center

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:** to replace part of blood that is missing or low in body, such as red blood cells, plasma, or platelets

5. **Indications for treatment/procedure:** Anemia, blood loss, hypotension, poor systemic oxygenation

6. **Anticipated Benefits of the Treatment/Procedure:** Improvement of anemia

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) __X__ 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: IV fluids such as saline

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:** Anemia

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: , MD

(e) **Who will administer Anesthesia:** Tulane 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: , MD

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

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 EFFECTS

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 blooding 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 Medical Center

Department of Urology
1415 Tulane Avenue
New Orleans, LA 70112-2699
Tel: (504) 988-5271
Fax: (504) 988-5393

Discharge Instructions
Robot Assisted Radical Prostatectomy

Date of Surgery: _____

Name: _____

DIET

You may eat or drink whatever you wish. Alcohol consumption in moderation is acceptable. Adjust your diet so that you avoid constipation. If you do become constipated take mineral oil and milk of magnesia. Do not have an enema - for the first 3 months after surgery your rectal wall is very thin and you may injure yourself.

AMBULATION

After you are discharged from the hospital you must avoid heavy lifting and vigorous exercise (calisthenics, golf, tennis, vigorous walking) for a total of 6 weeks from the day of surgery. It takes at least 6 weeks for firm scar tissue to develop in both your wound and in the areas where you underwent surgery. If you engage in strenuous activity before that time you might disrupt the delicate connection between your bladder and urethra; this could lead to long - term problems with urinary control or a hernia in the incision. During the first 4 weeks you are home do not sit upright in a firm chair for more than 1 hour. I prefer having you sit in a semi recumbent position (in a reclining chair, on a sofa, or in a comfortable chair with a footstool). This accomplishes 2 goals: 1.) it elevates your legs, thereby improving drainage from the veins in your legs which will reduce the possibility of clot information (see below); and 2.) it avoids placing weight on the area of your surgery in the perineum (the space between the scrotum and the rectum. While at home I would like you to have your Foley catheter connected to the large bedtime drainage bag most of the time. The leg bag should only be used occasionally if you plan to go out of the house. There are no other serious restrictions. You can walk up and down stairs. You may drive your car once the catheter has been removed if you are not requiring any narcotic medications.

PROBLEMS

Bleeding: It is not uncommon to have a bloody discharge around the catheter when you strain to have a bowel movement; do not become concerned; it will stop. Also, do not worry about some blood in the urine; it may arise from vigorous walking, the ingestion of aspirin or Motrin, or it may occur spontaneously. If a force fluid occurs the blood will dilute out so that it does not clot off the catheter and will encourage the cessation of bleeding. Blood in the urine usually has no significance and spontaneously resolves on its own.

Leakage around the catheter: This is very common especially when you're up walking around or having a bowel movement. The tip of the catheter is not in the most dependent part of the bladder; the balloon that holds the catheter in the bladder elevates the tip of the catheter away from the bladder neck. For this reason, when you are up walking around many patients have leakage around the catheter. This can usually be managed through the use of diapers or other absorbent materials. If your catheter stops draining completely, lie down flat and drink a lot of water. If after 1 hour there is not urine coming from the catheter it is possible that your catheter has become obstructed or dislodged. At that point contact me (see below).

Wound: You can take a shower immediately after you return home. I like to leave the skin glue in place for about one week after discharge because I believe that their presence encourages the development of a thinner scar. When showering for the first week, pat the incisions dry. Thereafter, you can trim off the loose edges as they loosen. Some patients develop a wound infection when they go home. This is manifested by some drainage from the wound. This can either be clear fluid (a seroma) or a mixture of blood and pus. In either instance it usually can be treated simply. Obtain some hydrogen peroxide and Q-tips; soak the Q-tip in the hydrogen peroxide and place it through the opening in the wound. This will keep the opening patent until all the material has drained. I suggest that you shower in the morning washing this area thoroughly (you cannot hurt it). After your shower use the Q-tip and then place a dressing over the site. Repeat the Q-tip and dressing before you go to bed that night. Feel free to call me for further advice (see below).

Clots in the legs: During the first 4-6 weeks after surgery, the major complication that occurs in 1-2% of men is a clot in the vein deep in your leg (deep venous thrombosis). This can produce pain in your calf or swelling in your ankle or leg. These clots may break loose and travel to the lung producing a life threatening condition known as pulmonary embolus. A pulmonary embolus can occur without any pain or swelling in your leg; the symptoms are chest pain (especially when you take a deep breath), shortness of breath, the sudden onset of weakness or fainting, and/or coughing up blood. If you develop any of these symptoms or pain/swelling in your leg, call me. Also, you should immediately call your local physician or go to an emergency room and state that you need to be evaluated for deep venous thrombosis or pulmonary embolism. If the diagnosis is made early, treatment with anticoagulation is easy and effective.

Urinary Tract Infection: Urinary tract infections are not uncommon following catheter drainage. They can be manifested in several ways. Before the catheter is removed the urinary may become permanently cloudy (see below) or you may develop some purulent drainage

around the catheter. This suggests that you have a urinary tract infection. Please call me and I will prescribe an antibiotic. Also, it is not unusual for some bacteria to be present in the urine. For this reason, many urologists will place you on an antibiotic for a few days after the catheter has been removed.

Urinary sediment: It is not uncommon for there to be some sediment in the urine. This can be manifested in a number of different ways. Old clots may appear as dark particles which occur after the urine has been grossly bloody. With hydration these will usually clear spontaneously. Also, the pH (acidity or alkalinity) of the urine changes throughout the day. After a meal the urine oftentimes becomes alkaline. There are normal substances in the urine called phosphates. They precipitate out in alkaline urine and form cloudy masses in the urine. If you see these periodically do not be concerned. This is a normal phenomenon. Finally, if the urine is persistently cloudy this suggests that an infection maybe present (see above).

Pain: Abdominal pain is common, but it is not located where you would expect it, i.e. in the midline. Rather it is either on one side or the other of the midline (it rarely hurts equally on both sides). The pain is from irritation of the abdominal muscles, sometimes it is where the drainage tube exited. It will resolve spontaneously. Try to avoid activities that bring it on.

Catheter removal: Your catheter should be removed 1 week from the day of surgery. One day prior begin taking Ciprofloxacin and continue for 5 days (if you are allergic to Ciprofloxacin you can call Dr. Lee for a different prescription). On the day you are going to have your catheter removed drink a lot of fluids before you arrive at the office. On that day I am only concerned whether or not you are urinating with a strong stream. The recovery of urinary control takes longer (see below).

COMMUNICATION WITH TULANE UROLOGY

If you have any problems when you are at home, call me. I can be reached at my office at (504) 988-5271. If you have an emergency at night or on a weekend call me at home: (504) 235-4830. If you cannot reach me then call the Tulane Medical Center at (504) 988-5800 and ask for the urology resident on call. My fax number is (504) 988-5393.

URINARY CONTROL

Problems with urinary control are common once the catheter is removed. Do not become discouraged. Urinary control returns in 3 phases: Phase I - you are dry when lying down at night; Phase II – you are dry when walking around; Phase III - you are dry when you rise from a seated position. This is the last component of continence that returns. Everyone is different and for this reason, I cannot predict when you will be dry. To speed up your recovery, practice stopping and starting your urinary stream every time you void (Kegel exercises). To do this, you must stand up to urinate. To shut off your urinary stream, contract your buttock muscles tightly. Only perform these exercises when you urinate. Do not do them at other times because you will fatigue the sphincter muscle. Until your control returns completely wear a pad or disposable diaper: Depends, Serenity pad, or an absorbent pouch for men (Promise for Men, Moinlycke Scott Health Care, 1-800-992-9939) or when you're almost dry, ConFiDenS, a special absorbent underwear, For information on ConFiDenS please write to: CFDS Dept REO, 2246 D Rome Drive, P.O. Box 88319, Indianapolis, IN 46208 or telephone (317) 291-4423. Do not wear an incontinence device with an attached bag, a condom catheter, or a clamp. If you do, you will not

develop the muscular control necessary for continence. Until your urinary control is perfect, avoid drinking excessive amounts of fluids. Also, limit your intake of alcohol and caffeine; both will make the problem worse. If you develop a red painful rash you may have a fungal infection, especially if you were treated with antibiotics. This usually responds well to treatment with Lotrimin cream, a non-prescription formulation that can be purchased over the counter.

SEXUAL FUNCTION

Erections return gradually. Be patient. If you had some degree of erectile dysfunction prior to the surgery it will be no better afterwards. Return of sexual function varies depending upon the age of the patient and the extent of the tumor. There are some patients who don't recover potency until two years after surgery. Furthermore, most patients continue to experience improvement of erection over the long term after the operation. Erections return gradually and quality improves month by month. The stimuli for erection during the first year will also be different. Visual and psychogenic stimuli will be less effective and tactile sensation will be more effective. Indeed, the major stimulus for erections during the first year postoperatively is tactile sensation. For this reason, do not be afraid to experiment with sexual activity, but I suggest that you wait until 6 weeks after surgery to be sure everything is well healed. After that time feel free to experiment. If you obtain a partial erection attempt vaginal penetration. Lubrication of the vagina can help. I have learned that Astroglide is much better than K-Y jelly and is readily available at loca1 drug stores. Vaginal stimulation will be the major factor which encourages further erections. Do not wait until you have the “perfect erection" before attempting intercourse. In addition, you should be able to have an orgasm even if you do not have an erection. With orgasm there will be no emission of semen because the prostate and seminal vesicles have been removed. When erectile function begins to return to many patients complain that they lose their erection when they attempt intercourse. This is caused by a venous leak. This can be overcome by placing a soft tourniquet at the base of the penis before foreplay. The purpose of this tourniquet is to retain the blood in the penis once blood flow increases secondary to simulation. Do not worry; this tourniquet will not impede the flow of blood into the penis. My patients have told me that rubber bands, ponytail holders or "erection rings" (which can be obtained from novelty stores) work. In addition, medications can be prescribed to help in rehabilitation of erectile function.

LONG TERM EVALUATION

Once we have had our first follow up appointment following the surgery and catheter removal, we will continue to check the PSA every three months for the first year. Thereafter you will need to have a PSA on a semi-annual basis. I would like to receive these reports at regular intervals so that I can follow your progress.

It has been wonderful taking care of you. I hope you will always consider me as your doctor and your friend. Good luck! You have had a good operation and you will do well!

Jonathan Silberstein, M.D.

L. Spencer Krane, M.D.

Raju Thomas, M.D.

Now that you have been treated for your prostate cancer and you are ready to be discharged, here are some discharge instructions to take with you.

If you have questions or concerns, please do not hesitate to call our Doctor's Hotline at (504) 988-2536.

TULANE UROLOGY
Cutting edge... Without the cut!

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THE TULANE UROLOGY TEAM

Wayne Hellstrom, MD, FACS
Andrology, Male Sexual Dysfunction, & Infertility

Benjamin Lee, MD, FACS
Robotic Surgery, Kidney Cancer,
Prostate Cancer, Kidney Stones

Margie Kahn, MD
Female Urology, Incontinence

Krishnarao Moparty, MD
General Urology

Oliver Sartor, MD
Medical Oncology, Prostate Cancer

Raju Thomas, MD, FACS, MHA
Robotic Surgery, Prostate Cancer, Kidney Cancer
Bladder Cancer, Kidney Stones

You can reach us by calling our Doctor's Hotline:
(504) 988-2536

TULANE UROLOGY

Tulane Urology Clinic
1415 Tulane Ave - 3rd Floor
New Orleans, LA 70112

WHAT NOW?

POST-RADICAL PROSTATECTOMY DISCHARGE INSTRUCTIONS

TULANE UROLOGY

FOLEY CATHETER CARE

The Foley catheter needs to drain by gravity and the drainage should not be restricted. The Foley catheter needs to be strapped to one of your thighs in such a manner that there will be NO tension or traction on the catheter.

Please make sure that the catheter does not kink or that the drainage of urine is not blocked.

The nursing personnel have taught you catheter care and on use of your leg bag. During the time that you are walking around, it is preferable that you have this leg bag in place. We recommend that the leg bag be switched from one leg to the other on every other day

It is also a good idea to maintain a reasonably accurate account of the drainage in the urinary bag to monitor your input and output.
Occasionally, you will see that there is urine leaking around the catheter. This is usually because of spasms of your bladder and if this is bothersome then, your urologist can call your pharmacy with a prescription to control the spasms.

SHOWER

You should shower on the evening of your discharge and thereafter. We prefer that the shower water clean up the incisions on your abdomen.

WOUND CARE

You will notice that there are several paper strips covering the small incisions on your abdomen. We recommend that this be removed in 72 hours postoperatively. Most of these should fall off after showering. However, if it does not fall off, we recommend that you use a warm towel to facilitate removal of these dressings.

RESPIRATORY CARE

We would advise that you use the incentive spirometry to perform the breathing exercises for the next few days after your discharge.

AMBULATION

The more you walk around the better. This will not only help prompt your bowel functions, but also prevent any blood clots from forming.

DIET

What we would recommend is that after your bowels feel normal that you be on high-protein diet. This will prompt healing after the surgical procedure. If you experience abdominal discomfort because of gas pains, we recommend that you take over-the-counter Gas-X or Milk of Magnesia laxative.

LIQUID INTAKE

We recommend that you drink as much water as is possible. This will help to maintain clear urine and wash out any clots that may form.
I hope that these instructions are helpful. However, if you have any questions, please do not hesitate to contact your Tulane Urologist at 504-988-5271, or your personal Urologist.

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