ASHFORD PRESBYTERIAN COMMUNITY HOSPITAL
SAN JUAN, PUERTO RICO

PHYSICIAN'S ORDERS

Prov. Diagnosis OB C/S Preoperative 	Name: Room No.:
Drug Allergies Weight:__________ Height:__________	Hosp. No.: Physician:

Do Not Use These	Date & Time Given	PHYSICIAN'S ORDERS	Nurse Noting Orders & Hour
Abbreviations		**General**	
		☐ DIAGNOSIS:________________________	
		☐ CONDITION: ☐ Critical ☐ Guarded ☐ Of care ☐ Stable	
		☐ VITAL SIGNS AND CHART: ☐ Q________Hrs ☐ Stat ☐ Now/Once	
		Nursing Orders	
		Assessments	
		⊙ Assess the risk of DVT	
		⊙ For patients undergoing scheduled cesarean delivery, the presence of fetal heart tone before surgery should be documented	
		☐ ASSESS PAIN	
		☐ ASSESS SMOKING STATUS	
		☐ P/ELECTRONIC FETAL MONITORING: Electronic fetal every:________________	
		Interventions	
IU		☐ ACTIVE PATIENT WARMING	
		☐ NEUMATIC STOCKINS	
QD		☐ PERIPHERAL VENOUS CANNULA INSERTION/MANAGEMENT	
Qd		☐ SURGICAL PREPARATION, GENERAL	
d		☐ INSERT FOLEY	
qod		☐ URINARY STRAIGHT CATHETERIZATION	
1.0			
		Patient/Caregiver Education	
.5		☐ EDUCATION, DEEP-BREATHING AND COUGHING EXERCISE	
		☐ EDUCATION, HEP B VIRUS SCREENING	
		☐ EDUCATION, HIV SCREENING	
MS		**Respiratory**	
MSO4		☐ NASAL CANULA AT________ LTS	
MgSO4			
		Diet	
CC		⊙ For patients undergoing elective cesarean delivery, avoid solid foods at least 6 to 8 hours prior to surgery	
µg		⊙ For patients undergoing elective cesarean delivery, consider allowing the consumption of clear fluids up to 2 hours prior to induction of anesthesia	
		☐ CLEAR LIQUID DIET	
		☐ NPO (NOTHING BY MOUTH)	

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Rev. RM 12/13

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Drug Allergies Weight:________ Height:________	

Do Not Use These Abbreviations

IU

QD
Qd
d
qod
1.0

.5

MS
MSO4
MgSO4

CC
µg

Date & Time Given	PHYSICIAN'S ORDERS	Nurse Noting Orders & Hour
	IV Fluids	
	⊙ For patients receiving intrathecal anesthesia, provide IV fluid preloading to reduce the incidence of maternal hypotension	
	☐ RINGER LACTATE 1000 ML at 125 ml/hrs intravenously	
	☐ SODIUM CHLORIDE 0.9% 1000 ML intravenously at 125 ml/hrs	
	☐ DEXTROSE 5%-WATER 1000 ML intravenously at 125 ml/hrs	
	Medications	
	Acid Suppression Agents: Alkalinizing Agents	
	☐ CITRIC ACID/SODIUM CITRATE (Bicitra) 30 milliliter orally once	
	Acid Suppression Agents: Histamine-2 Receptor Antagonists	
	☐ FAMOtidine (Pepcid) 20 milligram intravenously once	
	☐ RANITIDINE HCL (Zantac) 50 milligram intravenously once	
	Antibacterial Prophylactic Agents	
	☐ CEFAZOLIN SODIUM (Ancef) 1 gram intravenously once	
	☐ CEFOXITIN SODIUM (Mefoxin) 2 gram intravenously once 1 hour before surgery	
	☐ CEFOXITIN SODIUM (Mefoxin) 2 gram intravenously EVERY 6 HOUR X 24 HOURS	
	Gastrointestinal Prokinetic Agents	
	☐ METOCLOPRAMIDE HCL (Reglan) 10 milligram intravenously once	
	Group B Strep Prophylaxis: Reminders	
	⊙ For patients colonized with group B Streptococcus who have planned cesarean delivery prior to rupture of membranes or onset of labor, avoid group B streptococcal antimicrobial prophylaxis	
	Group B Strep Prophylaxis: Penicillin Nonallergic	
	☐ AMPICILLIN SODIUM 2 gram intravenously stat	
	☐ AMPICILLIN SODIUM 1 gram intravenously every 4 hours until delivery; maintenance dose	
	☐ PENICILLIN G SODIUM 5 million units intravenously stat	
	☐ PENICILLIN G SODIUM 5 million units intravenously every 4 hours until delivery; maintenance dose	
	Group B Strep Prophylaxis: Penicillin Allergic	
	☐ CEFAZOLIN SODIUM (Ancef) 2 gram intravenously stat	
	☐ CEFAZOLIN SODIUM (Ancef) 1 gram intravenously every 8 hours until delivery; maintenance dose	
	☐ CEFAZOLIN PHOSPHATE 600 mg (Cleocin) 600 milligram intravenously every 8 hrs. until delivery	
	☐ VANCOMYCIN HCL (Vancocin HCL) 1 gram intravenously every 12 hours until delivery	

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Drug Allergies Weight:________ Height:________	

Do Not Use These Abbreviations

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Date & Time Given	PHYSICIAN'S ORDERS	Nurse Noting Orders & Hour
	Laboratory	
	Blood Bank	
	⊙ For patients at low risk for hemorrhage, avoid the routine use of preoperative blood type and screen or	
	crossmath	
	☐ COOMBS INDIRECT	
	☐ BLOOD TYPE AND GROUP	
	☐ TYPE AND SCREEN	
	Chemistry	
	☐ CREATININE SERUM	
	☐ GLUCOSE, RANDOM	
	Hematology	
	☐ PLATELET COUNT	
	☐ COMPLETE BLOOD COUNT	
	☐ PTT	
	☐ PT + INR	
	Panels	
	☐ BASIC METABOLIC PANEL	
	☐ CMP	
	☐ RENAL PANEL	
	☐ LIVER PROFILE	
	Serology	
	● For patients who do not have a documented HBsAg test result, who are at risk for HBV infection during	
	pregnancy, or who have clinical hepatitis, perform HBV screening upon admission for delivery	
	● For patients with unknown HIV infection status, perform HIV testing, unless the patient declines	
	☐ HEPATITIS SURFACE ANTIGEN	
	☐ HIV	
	☐ RAPID PLASMA SURFACE ANTIGEN	
	☐ RUBELLA IGG	
	☐ RUBELLA IGM	
	Urine Studies	
	☐ UA (URINALYSIS)	
	Consult	
	☐ PHYSICIANS CONSULT	

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OB C/S PRE-OP

ASHFORD PRESBYTERIAN COMMUNITY HOSPITAL
SAN JUAN, PUERTO RICO

PHYSICIAN'S ORDERS

Prov. Diagnosis OB C/S Preoperative 4 of 4	Name: Room No.: Hosp. No.: Physician:
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Do Not Use These	Date & Time Given	PHYSICIAN'S ORDERS	Nurse Noting Orders & Hour
Abbreviations IU QD Qd d qod 1.0 .5 MS MSO4 MgSO4 CC µg		Laboratory	
		● For HIV - positive 38 weeks of gestation of greater with intact membranes who present before labor onset, cesarean delivery should be performed	
		● For HIV - positive patients with rupture of membranes or labor, the evidence for the most appropriate method of delivery is inconclusive	
		● For patients undergoing elective cesarean delivery, do not perform the procedure prior to 39 weeks of gestation	
		● For patients who request information on umbilical cord blood banking, a discussion on the advantages and disadvantages of umbilical cord blood banking should be initiated	
		● For patients with active genital HSV lesions or prodromal symptoms at the time of delivery, provide cesarean delivery	

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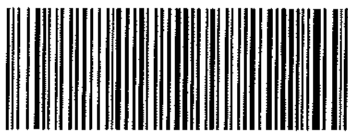

OB C/S PRE-OP

ASHFORD PRESBYTERIAN COMMUNITY HOSPITAL
SAN JUAN, PUERTO RICO
CONSENTIMIENTO INFORMADO PARA OPERACION / PROCEDIMIENTO

Patient Name:

Hospital No.:

Physician:

1. Autorizo al Dr. (s):________________________________, los cirujanos y/o cualquier otro médico, enfermero o paramédico que ellos designen para que le presten cooperación y ayuda para efectuar en ________________________ (Nombre del paciente) la operación, tratamiento o procedimiento diagnóstico siguiente :________________________________

____

2. La naturaleza y objeto de la operación, procedimiento, diagnóstico o tratamiento, así como las diversas opciones de tratamiento, si alguna, los riesgos involucrados y la posobilidad de complicaciones me han sido ampliamente explicados por el médico y consiento a que se realice la operación, tratamiento o procedimiento de diagnóstico descrito en el párrafo uno de este consentimiento. Reconozco que no se me puede ofrecer garantía absoluta en cuanto a los resultados que se esperan obtener. Entiendo que la medicina no es una ciencia exacta y que en el curso del tratamiento, operación o procedimiento diagnóstico se podría encontrar condiciones médicas de emergencias que requieren la extirpación de un órgano o el uso de otras técnicas operatorias y/o procedimientos médico-quirúrgicos a discreción del cirujano y/o la necesidad de administración de sangre.

3. Entiendo que pueden acontecer los riesgos y complicaciones siguientes que la ciencia médica reconoce podrián estar asociadas a dicha operación, tratamiento o procedimiento diagnóstico, por ejemplo: riesgo de infección, reacciones alérgicas o tóxicas a tratamiento, transfusión o medicamentos y hemorragias, y otros :________________________________

____

4. Entiendo que, aún aplicando todos los recursos en la ciencia moderna, algunos de estos riesgos y complicaciones pueden ser tan severos que, llevados a un extremo, podrían causar la muerte. Entiendo que antes, durante y después de la operación, tratamiento o procedimiento diagnóstico, se podría sufrir dolores y preocupaciones mentales que se reconoce que pueden estar asociadas a estos.

5. En caso que se requiera anestesia, consiento en que sea administrada por un médico anestesiólogo y autorizo el uso de aquellos anestésicos que crean convenientes.

6. Autorizo a los médicos arriba mencionados a las personas designadas por el hospital a llevar a cabo todos los estudios que crean necesarios de cualquier tejido, organo o parte del cuerpo que sean removidos y que dispongan de los mismos.

7. Autorizo ( ) No Autorizo ( ) que, como parte del Programa de Residencia en Obstetricia y Ginecología del Municipio de San Juan y bajo la supervisión del médico a cargo, médicos residentes participen en el cuidado de mi salud y en la operación, tratamiento o procedimiento de diagnóstico identificado en el párrafo número 1.

8. Otros :____

____

____

Certifico: Que he leído o me han leído y entiendo perfectamente este Consentimiento para Tratamiento, que se me hicieron todas las explicaciones y advertencias a que se hace referencia en el mismo, que toda la información correspondiente ha sido suministrada en los espacios en blanco y que antes de firmar se han tachado las cláusulas que no acepto y/o que no son pertinentes a mi caso.

Nombre del Paciente
o su Representante Legal: ________________________ Fecha: ___/___/___ Hora: ____________ am. pm.

Firma del Paciente
o su Representate legal: ________________________ Fecha: ___/___/___ Hora: ____________ am. pm.

Si es Representante Legal, Relación con el Paciente: ________________________

Testigo: ________________________

Firma Médico: ________________________ Fecha: ___/___/___ Hora: ____________ am. pm.

Revisado: RM 11/26/12

CONSENT SURGERY

ASHFORD PRESBYTERIAN COMMUNITY HOSPITAL
SAN JUAN, PUERTO RICO

INFORMED CONSENT FOR SURGERY AND PROCEDURE

Patient Name:

Hospital No.:

Physician:

1. I hereby request and authorize Dr. (s) ______________________________, the surgeons and/or other physician, nurses or other members of the health team that they designate to cooperate and assist him in performing on me, ______________________________ the following operation, treatment or diagnostic procedure:
(Patient's Name)

____

2. The nature and purpose of the operation, diagnostic procedure or treatment, the different options of treatment, if any, the risks involved and possible complications, have been fully explained to me by the physician, and I hereby consent to the operation, treatment or diagnostic procedure described in paragraph one of this consent. I am aware of the fact that an absolute guarantee, can not be offered as to the expected results. I understand that Medicine in not an exact science and that during the operation, other urgent medical conditions could be found, that, acorrding to the physician's judgement, might require the removal of an organ or the implementation of some other operation, technique and/or surgical procedures, and/or blood transfusion.

3. I understand that there are some risks and complications which medical science admits could be associated with the operation, treatment or diagnostic procedure. The most frequent of these are: infection, allergic or toxic reaction to treatment, blood transfusion, or medications, hemorrhages and others:______________________________

____

4. I understand that even though all the resource of the medical science and applied, some of these risks and complications could be so severe that in an extreme case, even death could occur. I understand that before, during and after the operation, procedure or treatment I could experience some degree of pain and anxiety that have been accepted to be related to them.

5. If anesthesia services are required, I consent that it be administered by an anesthesiologist, and I authorize the use of those anesthetics considered to be appropriate.

6. I authorize the physicians hereby mentioned or persons designated by them or the hospital to carry out all the studies they consider might be necessary on all tissues, organs and any other parts of my body that have to be removed, and to properly dispose of them.

7. I ( ) authorize ( ) do not authorize ( ) does not apply; that as part of the Obstetrics and Gynecology Residence Program of the Municipality of San Juan, and under the supervision of the attending physician, medical residents take part in my healthcare treatment and specifically in the operation, treatment or diagnostic procedure identified in paragraph number 1.

8. Other :____

____

I Certify: That I have read this consent or that it was read to me, and I perfectly understand the operation, procedure or treatment mentioned above that will be perfomed on me; that I was given all the explanations and warnings necessary and which are referred to in this consent, that the operation and/or dianostic procedure and/or treatment mentioned above have been throughly explained to me, that all the pertinent information has been written on the blank spaces, and that those clauses that I did not accept or that are not relevant to my case have been crossed out before signing this consent.

Patient Name or
Legal Representative: ______________________ Date:___/___/___ Hour:________ am. pm.

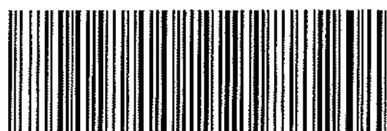
Patient Siganture or
Legal Representative: ______________________ Date:___/___/___ Hour:________ am. pm.

If Legal Representative, Relationship to Patient: ______________________

Witness: ______________________

Physician Signature: ______________________ Date:___/___/___ Hour:________ am. pm.

Revised: 12/13



CONSENT SURGERY