

**PAIN MANAGEMENT PHYSICIAN'S ADMISSION ORDERS  
SANTA BARBARA SURGERY CENTER**

Patient Name: \_\_\_\_\_

Admission Date: \_\_\_\_\_

Admitting MD:  Hullander

Mozingo

**ORDERS AND TREATMENTS:**

- |   |  |  |
|---|--|--|
| <input checked="" type="checkbox"/> Admit to SBSC                           | <input checked="" type="checkbox"/> NPO post: <u>8 hours</u>         | <input checked="" type="checkbox"/> Skin Prep: <u>Betadyne unless allergic</u> |
| <input checked="" type="checkbox"/> Hep Lock / IV: NS or LR at TKO or _____ | <input type="checkbox"/> Vancomycin 500 mg slow IVPB unless allergic | <input type="checkbox"/> Antibiotic: <u>Ancef 1 gm IV</u>                      |
| <input type="checkbox"/> Medications: <u>Fentanyl</u> - _____ mcg           | <input type="checkbox"/> Medications: <u>Versed</u> - _____ mg       | <input type="checkbox"/> If Allergic to Ancef, give: _____                     |

**Anesthesia:** circle one - GEN    MAC    CONSCIOUS SEDATION    NONE

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Epidural Block - Steroid    L    R | <input type="checkbox"/> Facet Block with Steroid:    L    R | <input type="checkbox"/> SI Joint    L    R          |
| <input type="checkbox"/> Rhizotomy    L    R                | <input type="checkbox"/> Sympathetic Block:    L    R        | <input type="checkbox"/> Stellate Ganglion    L    R |
| <input type="checkbox"/> Stimulator : Trial                 | <input type="checkbox"/> Stimulator : Permanent              | <input type="checkbox"/> Discogram                   |
| <input type="checkbox"/> Other: _____                       |  |  |

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> LUMBAR: _____ | <input type="checkbox"/> THORACIC: _____ | <input type="checkbox"/> CERVICAL: _____ |
|--|--|--|

**INFORMED CONSENT:** I have informed the patient regarding the nature of the treatment, the potential risk and complications, as well as the expected benefits. All questions have been answered. If Anesthesia or Sedation is planned, I have informed the patient of associated risks and potential complications.

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

**PROCEDURE POST OPERATIVE ORDERS**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Hold for Evaluation | <input checked="" type="checkbox"/> Discharge to Home           | <input checked="" type="checkbox"/> D/C IV / Heplock |
| <input type="checkbox"/> CT Scheduled        | <input checked="" type="checkbox"/> Discharge per PACU protocol | <input type="checkbox"/> Other: _____                |

**POST PROCEDURE NOTE**

PRE OP DX: \_\_\_\_\_

POST OP DX: \_\_\_\_\_

PROCEDURE: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ MD

\*\*\*\*\* Signature applies to post op orders and postoperative note.

**FAX OR MAIL TO:**

SANTA BARBARA SURGICAL CENTER, INC  
3045 DE LA VINA STREET  
SANTA BARBARA, CA 93105  
FAX: 805-569-2024

PATIENT STICKER HERE

Form 135    Rev 2008 11 26 WKG