

Beacon Orthopaedics Surgery Center
 fax # 513-823-2887
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Patient _____ D.O.B. _____
 Surgery date _____
 Surgical Procedure _____

Medical History <i>Circle if Applicable</i>		Assessment				Previous Surgery YES <input type="checkbox"/> NO <input type="checkbox"/>	
		Sys	NOR	ABN	Comments	List:	
1	Cold / Chronic Cough / Tuberculosis	HEENT					
2	Bronchitis / Emphysema/ OSA						
3	Asthma / Shortness of Breath	NECK					
4	Rheumatic Fever / Heart Murmur						
5	High Blood Pressure	CHEST					
6	Swelling of Feet / Fluid in Lungs						
7	Heart Attack	HEART					Allergies YES <input type="checkbox"/> NO <input type="checkbox"/>
8	Irregular, Fast Heartbeats					List:	
9	Bruises, Bleeding Easily	ABDOMEN					
10	Sickle Cell Anemia / Anemia						
11	Diabetic / Low Blood Sugar	EXTREM.					
12	Pregnant: No. of weeks _____						
13	Kidney Disease	M.D. Notes				Medications YES <input type="checkbox"/> NO <input type="checkbox"/>	
14	Jaundice / Hepatitis					List:	
15	Hiatal Hernia / Ulcer/ GERD						
16	Convulsions / Epilepsy / Stroke						
17	Meningitis / Paralysis						
18	Back Pain / Slipped Disc / Arthritis						
19	Psychological Disease						
20	Thyroid Disease						
21	Glaucoma						
22	Skeletal Deformities/ Disease						
23	Loose Teeth / Caps on Front Teeth						
24	History Anesthesia Complications						
	Self / Family						
25	Cancer / Leukemia / HIV	* K if on Diuretics					
Smoker : Pack / Day		* EKG needed for 50 or older or				Family History:	
Alcohol intake:		cardiac history					
Drug Abuse:							
Menstrual History:							
Menopause:							
Hysterectomy:							
LMP		Patient is medically cleared for surgery					
VS		YES <input type="checkbox"/> NO <input type="checkbox"/>					
Height							
Weight		Physician's Signature/ Date					



TEL: 513.354.7657 FAX: 513.823.2887

www.BeaconOrtho.com

BEACON ORTHOPAEDICS SURGERY CENTER

PRE-OPERATIVE TESTING ORDERS FOR TOTAL HIP AND PARTIAL/TOTAL KNEE ARTHROPLASTY

*Please give this form to your Primary Care Physician to fill out and fax to Beacon within 30 days of your surgery, but at least 7 days prior to surgery.

Patient's Name: _____

Pre-Operative Diagnosis: _____

Surgical Procedure: _____

Surgery Date: _____

History and Physical – within 30 days of surgery date

Please draw the following labs on EVERY patient: within 30 days of surgery date

- a. CBC w/differential
- b. BMP
- c. PTT
- d. PT/INR
- e. A1C if diabetic

***PTT and PT/INR required due to Spinal Anesthesia. Use diagnosis code M79.609**

EKG – All patients 50 years of age or older regardless of cardiac health within 3 months or patients with history of cardiac disease, MI, Angina, Stent placement or CABG

The following is to be ordered by PCP and/or Anesthesiologist

Chest X-Ray – Only if clinically indicated by changes in condition of the patient suggesting unstable cardiac or pulmonary condition.

Other: _____



Physician Signature

_____ Date

*****If the patient is on Warfarin, the PT/INR level should be drawn 2 days prior to their procedure after stopping their Warfarin**

****Fax all testing plus history and physical to (513) 823-2887 at least 72 hours prior to surgery date**

ANTICOAGULATION GUIDELINES

Neuraxial Procedures



Risk Spinal Hematoma with Neuraxial Procedures*

PRIOR TO NEURAXIAL/NERVE PROCEDURE
 Minimum time between last dose of antithrombotic agent AND neuraxial injection or neuraxial/nerve catheter placement

ANTICOAGULANTS — INJECTABLE	
Enoxaparin (Lovenox) — 40 mg SQ daily	≥ 12 hours
Enoxaparin (Lovenox) — 30 mg SQ q12h	≥ 24 hours
Enoxaparin (Lovenox) — 1.5 mg/kg SQ daily or 1 mg/kg SQ q12h	≥ 24 hours
Fondaparinux (Arixtra)	36-42 hours

ANTICOAGULANTS — ORAL	
Apixaban (Eliquis) — 2.5 mg BID - 5 mg BID	72 hours
Rivaroxaban (Xarelto) — 15-20 mg daily	72 hours
Betrixaban (Bevyxxa) — 80 mg daily	72 hours
Edoxaban (Savaysa) — 30-60 mg daily	72 hours
Dabigatran (Pradaxa) — 75-150 mg BID	5 days/120 hours
Warfarin (Coumadin)	4-5 days — verify normal INR

ANTIPLATELETS	
Aspirin	May continue unless otherwise recommended by surgeon
NSAIDs	7 days per surgeon recommendation
Aspirin/dipyridamole (Aggrenox)	24 hours
Cangrelor (Kengreal) IV infusion	3 hours
Clopidogrel (Plavix)	7 days
Prasugrel (Effient)	10 days
Ticagrelor (Brilinta)	7 days
Cilostazol (Pletal)	4 days
Ticlopidine (Ticlid)	10 days

*Guidelines do not address risks with multiple therapies or comorbidities that interfere with coagulation. Consult appropriate expert(s) as needed.

References: 1. Horlocker, J. et al. (2018). Regional Anesthesia in the Patient Receiving Antithrombotic or Thrombolytic Therapy. *American Society of Regional Anesthesia and Pain Medicine Evidence-Based Guidelines* (Fourth Edition). *Regional Anesthesia and Pain Medicine* 43(5):263-309. DOI: 10.1097/AAP.0000000000000763. 2. Gogarten, W., van den Broek, P., van Aken, H. et al. Regional anaesthesia and antithrombotic agents: recommendations of the European Society of Anaesthesiology. *Eur J Anaesthesiol* 2010; 27:999.