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Regional Pre-Printed Orders for
Cesarean Section Pre-operative

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DRUG & FOOD ALLERGIES

• **Mandatory** ☐ **Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.**

- NPO for solids after midnight
- Clear fluids until 3 hours pre-op, then NPO
- Primary IV: ❑ lactated ringers ❑ sodium chloride 0.9%
  - Adjust rate to maintain total IV intake at maximum: ❑ _____ mL/h OR ❑ 150 mL/h
- Insert indwelling catheter

❑ CBC

❑ Group and screen (medium or high risk of peripartum transfusion - see back page)

❑ **ranitidine** 50 mg IV one hour pre-op OR ❑ **ranitidine** 150 mg PO two hours pre-op with a sip of water

❑ **metoclopramide** 10 mg IV one hour pre-op OR ❑ **metoclopramide** 10 mg PO with a sip of water one hour pre-op

❑ **sodium citrate-citric acid** 3 g-2 g (30 mL) PO within 30 minutes of surgical start

Antibiotics: All infusions to be administered on-call to OR (within 30 to 60 minutes of surgical start)

Time antibiotic given: _____

Cesarean section elective or non-elective and low risk of developing postpartum infection

❑ **ceFAZolin** 2 g IV x 1 dose
Note: first-line unless history of severe delayed reactions* to penicillins or cephalosporins, or history of any allergic reaction to cefazolin

❑ **clindamycin** 900 mg IV x 1 dose

Cesarean section high risk of developing postpartum infection (see back page)

❑ **ceFAZolin** 2 g IV x 1 dose plus **metroNIDAZOLE** 500 mg IV x 1 dose
Note: first-line unless history of severe delayed reactions* to penicillins or cephalosporins, or history of any allergic reaction to cefazolin or metronidazole

❑ **clindamycin** 900 mg IV x 1 dose plus **gentamicin** (2 mg/kg) _____ mg IV x 1 dose

Current weight:_____kg (Prescriber must calculate weight based gentamicin dose if ordered)

*e.g., Stevens-Johnson syndrome, toxic epidermal necrolysis, or drug reaction with eosinophilia and systemic symptoms

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name and College ID#

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Peripartum Transfusion Risk Assessment

❑ Low	❑ Medium	❑ High
☐ singleton pregnancy ☐ less than 5 previous vaginal births ☐ no known bleeding disorder ☐ no history of PPH ☐ elective repeat cesarean section ☐ delivery plan includes: AMTS or PMTS following physiologic birth	☐ no prenatal care ☐ previous caesarean delivery in labour ☐ uterine surgery/myornectomy ☐ multiple gestation ☐ 5 or more previous vaginal births ☐ history of previous PPH ☐ uterine fibroids ☐ chorioamnionitis ☐ thrombocytopenia (platelets less than 100 $X10^9$/L) ☐ hemoglobin less than 100 g/L ☐ preeclampsia ☐ prior manual removal of placenta	☐ known difficult crossmatch/ antibodies ☐ placenta previa ☐ suspected placenta accreta, increta or percreta * ☐ hemoglobin less than 80 g/L ☐ active bleeding (greater than show) on admission ☐ placental abruption * ☐ thrombocytopenia (platelets less than 75 X 10^9/L) * ☐ known bleeding disorder (including von Willebrand disease; antibodies to Factor VIII; Factor X, XI, XIII deficiencies; anticoagulation therapy; DIC) * ☐ eclampsia *

Indications to **advance risk status one level** and implement associated interventions:

- ☐ **multiple risk factors**
- ☐ active bleeding
- ☐ chorioamnionitis
- ☐ severe preeclampsia/magnesium sulfate administration
- ☐ prolonged oxytocin use (greater than 12 hours)
- ☐ prolonged 2nd stage (greater than 3 hours)
- ☐ precipitous labour and birth
- ☐ assisted vaginal birth (forceps or vacuum)
- ☐ cesarean delivery urgent/emergent
- ☐ retained placenta
- ☐ suspected uterine rupture

*anesthesia consult required

Legend: **AMTS**: Active management of third stage refers to oxytocin administered after delivery of the anterior shoulder/baby; **DIC**: disseminated intravascular coagulation; **PMTS**: Physiologic management of third stage; **PPH**: Postpartum Hemorrhage

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Cesarean section high risk of developing postpartum infection:

- Active labour
- Maternal fever
- Rupture of membranes over 6 hours
- Failed forceps or vacuum

Timing of antibiotic prophylaxis[1]:

- Optimal time for administration of preoperative antibiotics is within 60 minutes before surgical incision to protect against bacterial contamination of the surgical site and decrease the risk of infection
- Single-dose prophylaxis is usually sufficient. Additional intraoperative doses may be warranted for patients with:
  - Excessive blood loss
  - Procedure duration exceeding the recommended redosing interval from the time of initiation of the preoperative dose (repeat **ceFAZolin** Q4H; repeat **clindamycin** Q6H)

[1]Bratzler DW et al. Clinical practice guidelines for antimicrobial prophylaxis in surgery. ASHP Report. Am J Health-System Pharm 2013;70:195-283.