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ALWAYS REMEMBER

Don’t worry, you’re not alone!

Hierarchy exists for a reason.

Assess the situation…
…then call your senior or your chief!

People you can always reach…

* The in-house senior surgery resident overnight *
* Anesthesia for patients in respiratory distress *
* The SICU fellow for decompensating floor patients *
* The on-call code team (Team 7000) *
* The medical teaching resident for any medical questions *

ALWAYS DO YOUR BEST… AND NEVER LIE.

(“I don’t know” is better than a lie!)
2 | WHAT IS S-B-A-R?

S-B-A-R is Mount Sinai’s Hand-Off Communication Policy.

**Situation** is used to identify a caregiver and patient (name, age, sex, DOB, MRN, diagnosis, etc) and a brief statement of the patient’s condition.

“I am concerned about Mr X as he is POD#4 s/p colectomy and…”

**Background** is for the patient’s most up-to-date and accurate condition with information such as medications, vital signs, pre-op mental status, etc. as appropriate to the situation.

“Mr X is currently febrile to 38.7 and tachycardic to 110s, though his pressures, mental status and abdominal exam are stable”

**Assessment** is for the caregiver to convey his/her professional opinion of the situation.

“I think Mr X may be septic from a leak, though a pneumonia is also possible…”

**Recommendation** is for the caregiver to state his/her request or recommendation. The caregiver may request a specific test or that another provider see the patient immediately. The caregiver should include a state of what to anticipate.

“I’d like to know what antibiotics you think we should start Mr X on. When do you think you will be able to see him? I’ve already ordered a stat CXR, blood and urine cultures, is there anything else we need in the meantime?”
THE SURGICAL NOTE

Subjective
New events or complaints overnight
Bowel function – flatus? BM?
Diet – tolerating PO? N/V?
Pain control – using PCA? asking for meds?
Ambulating?
Other complaints – chest pain? SOB?

Objective
Vitals: Tmax/24h, Tcurr, BP, HR, RR, Sat
   Ins IVF at rate? + boluses?
   Outs Urine/shift + voiding vs Foley
Drains/shift + quality
Ostomy/shift
Exam: General
   Heart
   Lungs
   Abd
   Wound
   Extremities

Assessment and Plan
☐ Advance diet?
☐ IVF or medication changes?
☐ Studies, labs to check?
☐ Ambulate, OOB, Venodynes, SQH?
☐ DC Planning – VNS for wound or drain care? PT consult?
4 | THE ON-CALL CHECKLIST

Remember: Unstable patients take priority over all else!

☐ Print list
☐ Pre-round on all inside patients and any nearby outside patients
☐ AM rounds
☐ Write/Drop notes (separate from med student notes)
☐ Run list with other juniors and PA and assign tasks
☐ Place orders
☐ Call radiology early and as often as needed to get imaging studies done or read
☐ Call consults early
☐ Check AM labs, call chief/senior re: abnormal labs
☐ Discharges: Rx, follow up appointments, medication reconciliation, social work needs, discharge orders
☐ Round with social work (10AM for 10E)
☐ Check prelim OR schedule for tomorrow (ie – preops?)
☐ Pre-ops for tomorrow (see pre-op checklist)
☐ Keep chief posted about any new patients on the service via ED or direct admit and review plans
☐ Check Sign-Out to watch for new post-op patients on list
☐ Prepare for PM rounds: chart check, get vitals, see patients, follow up studies
☐ PM rounds: know what labs need to be ordered for tomorrow, know what final studies/consults need to take place tonight vs. those that can be deferred
☐ Post-op checks in order of OR time and case complexity
☐ Check final OR schedule after 6pm
☐ Update sign out
☐ Sign-out to NP if on short-call using SBAR: stress priority of tasks and what chief needs to know about
☐ Document A/P for patients you are called to see overnight
5 | THE PRE-OP CHECKLIST

- Confirm exact procedure with chief/attg,
- Elective/scheduled? Or needs a pink slip?
- if pink slip, is it category 1 (OR within 1 hr) or category 2 (OR within 6 hrs)
- Labs: CBC, Chem7, Coags with date; AM K+ in HD pts
- T&S: call bloodbank to make sure it’s active (~72 h)
  - Second T&S needed for all pts new to hospital!
- Products on hold: 2 units pRBCs, FFP if elevated PTT or INR, platelets if low plts
- Beta HCG or urine pregnancy test within 24h for all women w/ period in last yr
- EKG if indicated
- CXR for pts > 60, smokers, pts with pulmonary disease
- Call film library if attg wants films in OR (ie. angiograms)
- Medical/cardiac clearance: POMAF for ASA 3+
- Renal clearance for ESRD pts – HD patients need dialysis day before surgery, arrange with ESRD fellow
- Medication review
  - Anticoagulation: SQH, heparin gtt, coumadin, aspirin, Plavix → ask chief/attg if should be held
  - Long acting insulin (i.e Lantus, NPH). If Type 2 diabetic and pt NPO, half the dose. Never stop long-acting insulin in Type 1 diabetics; call endocrine.
- NPO-post-midnight except meds, hold tube feeds
- IVF after midnight at maintenance. gentle for cardiac/CHF pts, none for ESRD/severe CHF pts
- Bowel prep- ask attending
- Consent: full procedure, no abbreviations, side
  - Needs witness: RN, phone interpreter with ID#
  - If no capacity, call health care proxy (HCP) if documented or next of kin, write down telephone #
  - Place in consents section of chart
- Tell 1° team & RN plan for OR, NPO, labs needed, etc
6 | THE OR CHECKLIST

☐ Show up 15 min before start of case in holding area
☐ If not 1st case, call holding area or core desk for updates
☐ If OR ready but patient missing, find them! Call GP2 for outpatients, floor for inpatients, or go to investigate delay
☐ Complete paperwork
  - Consent
  - New H&P or update form if H&P within 30 days
  - PreOp Medical Assessment Form (by PMD/TR): ASA
  - Site/Side form
  - Pathology form
☐ Ensure attg has co-signed the consent, H&P, POMAF
☐ Mark patient on side and site of surgery with your initials
☐ Make sure circulating RN has seen patient
☐ Make sure anesthesia has seen patient
☐ Check if room is ready
☐ Bring patient + chart into room
☐ Check safety strap, venodynes
☐ Antibiotics / Foley / shave / position as needed
☐ Prep if ok with attending

After the case:
☐ Ask attg what Rx’s & f/u appointments are needed
☐ Help get patient to the stretcher and into the PACU
☐ Write the operative note or help student to write it
☐ Write discharge orders in Epic using Amb Surg order set
  - DC & PACU orders, ie CXR or void check
  - DC instructions
  - DC prescriptions
☐ If patient is being admitted, put in orders & add to list, tell your team, sign out the postop check
☐ Save a sticker and log your case at acgme.org
☐ Dictate if applicable
THE BRIEF OP NOTE

Template is available in EPIC.

Pre-op diagnosis
Post-op diagnosis
Indications
Procedure
Surgeons
Anesthesia
Findings
EBL
Drains
IVF and urine output
Specimens
Cultures
Complications
Condition
**Use the appropriate surgical post-op order set on Epic**

**SIGN OUT** your case to your on-call colleague or the primary service taking care of the patient immediately!

**General principles:**
- Admit to [Floor/Service]
- Diagnosis
- Condition
- Vitals’ frequency
- Allergies

**Nursing orders**
- Strict I&Os qshift
- Tubes & drains, suction settings, etc
- Venodynes in bed
- Notify MD conditions

**Diet**

**Activity**

**Labs:** post-op, next AM (alert PACU RN to post-op labs)

**IV Fluids**

**Special imaging:** ie. CXR or next day upper GI

**Medications**
- Antibiotics with dc date or number of doses if peri-op
- Anti-hyperglycemics
- Anti-hypertensives **always** with hold parameters
- Anti-emetics prn
- Bowel regimen
- DVT prophylaxis
- GI prophylaxis
- Pain management
THE POST-OP CHECK

* Should be done 4-6 hrs after the end of surgery.
* This is a crucial assessment as many post-op patients have just undergone huge volume shifts and need to be monitored closely.
* This is the time to catch post-op bleeding early.

- Ask the patient about chest pain, shortness of breath, and pain control at the surgical site
- Check PACU and recent floor vitals and fluid trends – look at trends, watch for tachycardia and hypotension
- Check urine output – minimum of 0.5cc/kg/hr since OR
- Check drain (JPs, NGT, G-tube, etc.) outputs
- Examine the patient
  - Is the pt alert or overly sedated?
  - Are tubes connected properly and working? Flush NGT
  - Check the dressing: alert senior/chief if saturated
  - Check quantity and quality of drain outputs: can send fluid for hematocrit if very sanguinous
  - For vascular pts: check pulses and compare to immediate post-op exam, should be marked
  - Venodynes working?
  - Incentive spirometer at bedside? Educate pt on use
- Check post-op labs and order new ones if necessary
- Check post-op CXR if indicated
- Review post op orders and make sure appropriate drugs are continued or discontinued
- Document your encounter with date and time!
10 | DIETS

* Clear liquid: anything you can see through, ie. Jello
* Full liquids: all liquids, including dairy
* GI soft/low residue: regular food but no hard-to-digest fiber/veggies/nuts/seeds; for anyone with GI anastomosis/ostomy
* Heart healthy: low fat, low cholesterol
* Carb controlled, AKA diabetic. 1800 kcal ADA: for diabetics, low sugar
* Special diets: Bariatric Stage I and II, dysphagia diets, renal/dialysis diet, enteral feeds, etc

11 | GI PROPHYLAXIS

* H2 blocker or PPI for all abdominal surgery patients (prophylaxis is not indicated for thyroid/parathyroid patients generally)
* Indicated for anyone with an NGT
* Indicated for anyone with a suspected GI bleed
* Continue PPI if patient already on at home
* IV Nexium requires pharmacy approval – only for patients with suspected active GI bleed. Call the pharmacy to order it; they need to order it for you through Epic.
* For TPN patients, H2 blocker is typically mixed into TPN – thus, if you dc TPN, remember to start GI prophylaxis again.
Indications for artificial nutritional support include pre-existing nutritional deprivation (ie, in Crohn’s or short-gut patients), anticipated or actual inadequate energy intake by mouth (ie, in an elderly patient s/p colectomy whom you anticipate won’t be taking PO for >7 days), or significant multiorgan system disease.

TPN consists of predetermined amounts of carbs, amino acids, fats, vitamins, minerals. The formula needs to be rewritten and ordered daily to every other day and submitted to the TPN pharmacy. At Mount Sinai, surgical patients who need TPN can have TPN ordered and managed either by the Surgical Nutrition Support Service (SNSS = same team as line service based in SICU) or by an attending endocrinologist. TPN for SICU patients is managed exclusively by SNSS.

To start TPN:

1. Your patient must have a central line. Arrange by calling line service (p1872)
2. You must consult SNSS (p1872) or the endocrine attending directly (check with chief to ask whom who should contact)
3. You should have Chem-10, LFTs including albumin, and triglycerides drawn, initially daily then 3-4x/week
4. Same day TPN orders are due by 11am in TPN pharmacy (46601)
**13 | IV FLUIDS**

For virtually all large operations in non-cirrhotic patients, post-op fluids should be isotonic (i.e. NS, LR, Plasmalyte). Post-op patients are in a high catecholamine, high ADH state, so resuscitative fluids are indicated for volume expansion. Re-assess fluid status in 2-3 days and if resuscitation not needed, convert to "maintenance" (½NS at hourly rate of 40 + weight in kg, i.e. 110cc/hr for 70 kg patient). Don’t forget ostomy and NGT losses—consider 1:1 replacement. **NEVER** bolus patients with ½NS or fluids containing potassium.

On Surg Onc, cirrhotic patients post-hepatectomy are on strict albumin drip protocols. **NEVER** bolus cirrhotics with crystalloids without clearing with chief or attending first.

**14 | REPLETING ELECTROLYTES**

Always recheck values after repleting electrolytes. It may be ok to wait until next day AM labs, but if a patient is symptomatic or risk of inadequate repletion is high, recheck immediately. If you don’t know the dosing, call pharmacy.

**Potassium:** Goal >3.5, if CAD >4.0, for all < 5.2

**Hypokalemia**
- Replete in all patients EXCEPT ESRD patients. Their K will continue to rise until next HD. If post-dialysis labs show hypokalemia, recheck in a few hours. If their potassium is still really low (i.e. after SEVERAL hours or next day), then ask on-call ESRD fellow if OK to replete.
- 10mEq of IV KCl raises serum K+ by 0.1
- If K <3, give 3 runs of 10mEq KCl IV at 1 run per hour and give 40mEq PO stat. 10mEq only through IV, 20 mEQ only through central line
- can give K orally in patients tolerating diet
- If K <3.5, give 10mEq packets of KCl, as many as needed for appropriate rise. If more than 40mEq is needed, divide doses by at least 2 hours. Oral potassium causes diarrhea.
- low Mag can make K difficult to replete

**Hyperkalemia**
- Check EKG, ask if patient is symptomatic (i.e. chest pain)
- If the patient is asymptomatic and no EKG changes, give kayexelate 15-30mg PO stat (only if pt has bowel fxn)
- If the patient is symptomatic or if there are EKG changes, give calcium gluconate/chloride, regular insulin IV (usually 10 units) + dextrose (D50), kayexalate, consider albuterol. Recheck K! Patient may need HD.

**Magnesium:** goal >1.5, if CAD >2
- 1g MgSO4 raises serum Mg 0.1 to 0.2
- If Mg<1.2, give 1g over 1 hour x2 and recheck
- If Mg>1.2, give 500mg Calcium gluconate PO or 1g IV over 1 hour

**Calcium**
- Always correct for albumin: Serum calcium falls 0.8mg/dl per 1g/dl drop in albumin < 4. Check ionized calcium level.
- If calcium is difficult to correct, check magnesium. Low Mg can make it very difficult to replete calcium.
- If mild and asymptomatic, give 1g PO qd
- If <7 and symptomatic, give 1-2g calcium gluconate over 10-15 minutes and 0.5-1.5mg/kg/hr

**Phosphorus**
- More relevant for critically ill, malnourished, and severely debilitated patients, liver resections.
- New hypophosphatemia after starting TPN or feeds in malnourished patient may be sign of re-feeding syndrome. May replete with IV/PO regimens (oral neutrophos in patients tolerating PO is fine)
* **Early ambulation:** You can write a nursing order for this (OOB or ambulate today)

* **Venodynes:** All post-op patients unless contraindicated (i.e. known DVT in that leg)

* **SQ Heparin:** Usually ok to start right after surgery but this can be attending dependent, so check with your chief or the attending directly and verify preferred dose (5000 units SQ q8h, or q12h if specified by attending)

* **SQ Enoxaparin:** As directed by chief/attending (40mg SQ daily for abdominal surgery)
**Heparin drip (IV)**
- For patients who are pre-op or fresh post-ops as effect can be reversed over \(~6h\) by stopping the drip
- Must know goal PTT (usually 60-80, sometimes 50-70)
- Generally start at 1000 units/hr (12-18U/kg/hr depending on indication) then check PTT in 6 hrs. For every 10 below or above target PTT, increase or decrease drip by 100 units/hr (i.e. PTT 42 increase drip to 1200 units/hr) and recheck PTT in 6 hrs. Continue until target PTT is reached and maintained \(x\) over 12 hrs, then continue drip at steady rate and check PTT daily.
- Make sure RN is aware of changes in infusion rates and check that PTT draws occur at proper time

**Coumadin (PO)**
- Needs to be ordered daily based on that day's INR until therapeutic
- Target INR is 2-3 for DVT, PE, a-fib; 2.5-3.5 for prosthetic heart valves (depends on type of valve)
- Typically start with 5-10mg at bedtime, but ask chief
- Reversed by vitamin K (PO, subQ or IV) and FFP

**Enoxaparin**
- Used as bridge to coumadin for patients nearing dc date
- Use 1mg/kg q12h SQ, for renal patients: 1mg/kg daily SQ
- For teaching, RN must show patient/family member first dose, patient/family member must perform 2nd dose under supervision. VNS can sometimes check in for up to 4 visits
- If patient/family member cannot be taught, VNS must be set up for day 1 after dc (talk to SW, fill out Briggs)
For help with management, can always page 917GLUCOSE

First, know if your patient is Type 1 (autoimmune disorder, insulin dependent) or Type 2 (may be on oral regimen +/- insulin). NEVER STOP insulin in Type 1 diabetics.

**Insulin at Sinai**
- **Aspart** (very short acting): Given with meals TID or as part of sliding scale (AISS).
- **Regular** (short acting): Not used often on floors, can be used in sliding scale (RISS).
- **NPH** (intermediate acting. Peaks 6 hours, lasts about 12): Favored in ICU at Sinai, dosed q6h to q8h
- **Lantus** (Long acting 24 hours, does not spike): Favored on floors, dosed q24h, sometimes q12h

**Post-op glucose management in Type 2 diabetics**
- If patient has Type 2 DM and takes long-acting insulin (Lantus/NPH) at home, CONTINUE the insulin post-op at half the dose (even if they are NPO and EVEN if their glucose levels are normal).
- If patient was a Type 2 diabetic on oral hypoglycemics only, use a sliding scale for 24 hours and monitor insulin requirements, then...
  - If persistent hyperglycemia, begin low-dose Lantus dosed 0.1 units/kg daily (i.e. 7 units for 70kg patient) usually given at night
  - Adjust Lantus daily by 20% based on AM FS.
  - If patient was hyperglycemic pre-op or immediately post-op, or required several hypoglycemic agents pre-op, then starting low-dose Lantus immediately post-op is appropriate.
* When patient resumes diet, additional insulin may be necessary. If this is the case, start aspart to be given immediately after each meal (hold parameter if patient eats <50%). Generally you may start aspart at 2-3 units per meal and adjust. The nurses should continue giving sliding scale adjustment doses before the meal. Immediate post meal finger sticks are not indicated.
* For dosing when patient eating: For breakfast dose, see pre-lunch finger stick and titrate up/down. For lunch dose, see pre-dinner finger stick and so-on. Generally you should aim to have patients on equal doses of meal time and basal (i.e. Lantus) dosing. For example, if a patient is on 18U lantus QHS, then mealtime dosing should be 6Units with each meal. It is unsafe to have a much higher long-acting dosage in patients who are eating.

**Glucose Management Pearls**
* Patient being "NPO" is *not* a contraindication to long-acting insulin. This is a widespread misconception.
* Never increase insulin by more than 20% daily.
* Type 2 patients on long-acting insulin made NPO should have their insulin dose halved (but not discontinued).
* New hyperglycemia in a non-diabetic or borderline diabetic sometimes signals early sepsis.
* Always DC metformin for any inpatient. If NPO, also dc other oral-hypoglycemics.
* Keeping a patient on a "sliding scale" for more than a day or two with persistent hyperglycemia (daily glucose levels >180) is inappropriate!
* Diabetes is often diagnosed post op, so make sure these patients are aware and have appropriate follow up. Order an A1C.
* Remember that steroids make glucose management difficult, and therefore insulin needs may change with steroid tapers.
Take your patient’s pain seriously!! It needs to be thoroughly investigated and adequately controlled.

**Oral options**
- Tylenol +/- codeine or Ibuprofen prn mild pain
- Percocet 1-2 tab q4h prn mild-moderate pain
- Dilaudid 2mg q3h prn moderate pain

**IV options** (for patients NPO or without adequate GI function)
- Morphine 2-4mg IV q4h prn severe pain
- Dilaudid 0.2-1.0mg IV q3h prn severe pain (1mg dilaudid is about equal to 7.5 morphine. so go slow starting out)
- Depends on weight and tolerance
- Always include hold parameters for low RR or BP
- Toradol 30mg q6h x 5 DAYS (always check with chief or attending first given reported risk of bleeding from platelet inhibition AND precipitation of hepatorenal syndrome in cirrhotics!)
- IV Tylenol from pain service

**Patient Controlled Analgesia (PCA)**
- **AVOID** basal rates as they can lead to respiratory depression more easily
- **AVOID** prescribing oral and IV opioids on top of PCA
- Morphine, fentanyl, or dilaudid PCAs, with opioid-sensitive, opioid-naive, or opioid-tolerant settings
- In a patient new to PCA can start with opioid-sensitive and increase as needed
- If patient has PCA and still in pain → are they ACTUALLY using it? Interrogating PCA history is easy (ask pain fellow to show you how)
Pain Management Pearls

* For post-op patients who are difficult to manage, consult pain service (p2738). For patients with terminal or chronic pain-inducing illness, consult palliative care (p9399).

* If your patient is receiving opioids and found to be in respiratory depression, stop all opioids immediately and have naloxone (Narcan) ready. Mix 0.4mg in 10cc normal saline and give 2-3cc every few minutes until reversal achieved. Repeat as needed. Consider narcan drip afterwards as narcotic half life longer than narcan (0.1mg/kg/hr).

*Don't forget senna/colace for patients on several days or more of narcotics and without diarrhea
ID consults are common at Sinai. However, just because a consulting physician/team is following a patient doesn't mean you stop following cultures and the clinical status of a patient's infection. Use SCC to investigate your patients' previous infections. You can also login with "test" temporarily. Be familiar with bug susceptibility trends at main Sinai website ➔ med-services ➔ antibiogram to review bug susceptibility trends.

**Prophylaxis:** Peri-operative antibiotics are prescribed to prophylax against surgical site infections, or less common endocarditis in patients with artificial valves. Almost always should only be for ONLY 24 hours peri-op, usually one dose pre-op and two doses post-op. Make sure this is not extended otherwise you risk complications like c-diff, diarrhea, resistance, etc.

**Empiric therapy:** The fundamental principle of antimicrobial therapy for intra-abdominal infections is to utilize agents effective against aerobic, facultative anaerobic (i.e Enterobacteriaceae like e-coli), and anaerobic organisms (particularly Bacteroides fragilis). Start broad, then narrow. Different hospitals and even different ID doctors use different cocktails. Below are the Sinai trends.

**Cholecystitis/Appendicitis/Diverticulitis regimens**
- Kefzol/Flagyl
- Cipro/Flagyl
- Unasyn* (covers enterococcus)
- Zosyn* (covers pseudomonas)
- Third generation cephalosporin + Flagyl
- Ertapenem* (doesn’t cover pseudomonas/acinetobacter)
If true penicillin allergy:**
Cipro/Flagyl
Clinda/Aztreonam (Clinda for the gram positives and anerobes, and aztreonam for the gram negatives)

*Needs ID approval

**Allergy: The great majority of patients with penicillin "allergy" aren't really allergic. Before you label them, investigate and document the previous drugs they have tolerated. A reasonable approach is that cephalosporins can safely be given even to penicillin-allergic patients as long as they did non experience ANAPHYLAXIS. (For further reading, see Pichichero ME. Cephalosporins can be prescribed safely for penicillin-allergic patients. J Fam Pract 2006;55(2):106-12.)

Surgical Site Infections

Superficial SSI (above fascia) can usually be treated with open drainage (ie, remove a few staples). If marked erythema/cellulitis/fever then add antibiotics. Kefzol usually fine (unless patient has already been on Kefzol for several days).

Deep SSI needs drainage (IR or re-lap) plus antibiotics.
**Antibiotics Pearls**

* Pseudomonas is only empirically treated with a few antibiotics choices: Cefepime, Ceftazidime, Pipercillin/Tazobactam (Zosyn), Cipro/Levofloxacin. BIG ID guns Imipenem, Amikacin

* If using Zosyn or Unaysn, avoid adding Flagyl for anaerobic coverage. Only use Flagyl for treating c-diff, or in addition to an antibiotic (i.e. Kefzol or Cipro) that doesn't cover anaerobes.
NGT = Nasogastric or salem sump tube = device used to suction gastric contents for patients with obstruction/ileus, proximal GI anastomosis, upper or lower GI bleed
- Salem sump NGT has 2 lumens: 1 sucks stomach contents into external canister, 1 sucks external air (via the blue air-port) into stomach immediately suctioned back into wall canister, thus preventing the internal tip from getting stuck to the gastric mucosa. Cork with white side facing out.
- Typically placed on low continuous suction
- If not draining, need to first flush the tube by disconnecting from wall suction, inserting ~20cc saline via bulb syringe into tube and releasing the bulb. You should see gastric contents coming back into the bulb syringe. If not, next step is to take off nasal tape and manipulate NGT until gastric contents are returned. May need to check CXR for positioning.
- For feeding can use a much smaller simple feeding tube (single lumen)

OGT = oropharyngeal tube is preferred over NGT for patients who need a tube long-term.

JP = Jackson Pratt = closed suction device with flat, white internal portion with multiple holes, generally considered for removal after output < 30cc/day

Blake drain = similar to JP but internal portion is same size as rest of the drain and has four longitudinal channels

Penrose = open rubber tube allowing free drainage

G-tube = gastrostomy tube placed in OR in open fashion (vs. PEG = percutaneous endoscopic gastrostomy placed by GI), for long-term feeds in patients who can't take sufficient PO

J-tube = jejunostomy tube placed in OR for patients whose gastric outlet / duodenum / biliary tree must be bypassed
**CENTRAL LINES**

**TLC** = Triple lumen catheter = short-term central venous catheter for TPN, IV antibiotics or poor peripheral access; needs to be changed every 7-10 days, cannot send patients home with these

**Hickmann / Broviac** = long-term tunneled central venous catheter for TPN, long term IV antibiotics, poor access

**Shiley** = short-term large-bore catheter for dialysis or plasmapheresis; used as bridge to permcath or AV fistula

**Permcath** = long-term large-bore catheter for dialysis or plasmapheresis; used as bridge to AV fistula

**Portacath** = long-term catheter with subcutaneous reservoir used for chemotherapy, poor access in need of IV meds/transfusions

**PICC** = Peripherally inserted central catheter = long-term small-bore catheter for TPN, antibiotics; should not be used for blood-draws; should only be placed when patient is about to leave hospital (infection risk)

**To get your patient a line...**

- Call **Line Service** for TLC, Shiley, PICC; **Vascular or IR** for permcath; **General Surgery** for portacath
- Line Service is busy so call ASAP! (x37393, p1872)
- Have the following information available:
  - Patient name, MRN, patient location?
  - Why and when is the line needed?
  - What are the most recent coags and platelets?
  - Is the patient stable? Is the patient DNR/DNI?
  - Is patient consentable & English-speaking? (If not you have to obtain consent and place in chart.)
  - Place brief orange consult form in chart
22 | POST-OP PROBLEMS: FEVER

* Fever = Temp > 38°C or 100.4°F

* Get a history and examine patient for obvious signs of infection (ie. look at wound, look at peripheral IV sites for phlebitis)

* Check CBC, send off blood cx, UA, urine cx, check CXR (if stable, can go to radiology for AP/Lat films), consider wound cx

* Remember the Ws and rough timeline
  - Worst (POD0: necrotizing fasciitis, early anastomotic leak if very high fevers)
  - Wind (POD1: atelectasis... debatable)
  - Water (POD3: UTI-almost never in surgical patients, anastomotic leak)
  - Walk (POD5: DVT/PE)
  - Wound (POD7: surgical site infection, abscess)
  - Wonderdrugs

* Fever on POD#0 and POD#1-2 most likely due to stress/tissue-inflammation related to surgery, not usually worked up. However, very high fevers should be taken seriously.

* Fever in the setting of rising WBC, tachypnea, and/or tachycardia may be indicative of early sepsis. Definitely notify a senior immediately.
* Ask the nurse to recheck all the vitals while you are on your way. Put on oxygen. Then go see the patient…right away!

* Stable or unstable? If unstable, call someone for help while you start to address the problem

* Check the vitals. Get a portable O2 sat machine in room.

* Interview and examine the patient, focusing on cardiopulmonary system
  - Cardiac: HF, MI
  - Pulmonary: PE, COPD, asthma, aspiration, pneumothorax
  - Sudden onset or subacute or chronic?
  - JVD, accessory muscles, lung sounds, heart sounds

* Diagnostic actions to consider
  - ABG, EKG, stat portable CXR (follow up and call radiology to look at it with you)
  - Nebulizer treatments/albuterol
  - Empiric lasix if lungs are congested and CXR wet (ask chief)
  - Empiric heparin bolus if clinical suspicion of PE is extremely high (ask chief)
  - Consider calling anesthesia/respiratory for elective intubation if patient is really in distress (if you call, start setting things up like suction, ambu-bag)
  - Consider transferring the patient: 10E step-down or SICU, or ask SICU fellow to see the patient
  - If adjustments necessary, increase their dose or switch to another narcotic. If still no success, call pain-service.
**POST-OP PROBLEMS: CHEST PAIN**

* Stable or unstable? Think about recent events: OR, line or chest tube pulled, new medication, etc.

* Check vitals, EKG, order stat portable CXR

* Interview and examine the patient!

* Things to think about: MI, PE, angina, pneumothorax, esophageal spasm/inflammation/rupture, reflux, aortic dissection

* If you suspect MI: “MONAB” (morphine, oxygen, nitrates—if BP allows, ASA 325 chewed, beta-blocker)

* If you suspect PE, get an ABG

* Labs: CBC, Chem 10, Coags, Troponins q8h x 3 sets, CK

* TR or cardiology consult? Start heparin drip? CT Angio?

* Should the patient be in a more monitored setting? (Step-down, ICU)

* Call someone else (senior, chief, attending, teaching resident, cardiology fellow, etc), but have an assessment and a basic plan first

* Anxiety/musculoskeletal pain do cause chest pain, but don't assume they are the cause!
25 | POST-OP PROBLEMS: TACHYCARDIA

* Stable or unstable? If unstable → ACLS algorithm.

* Check BP, urine output, JP outputs, O2 sat

* Get an CBC, ABG, EKG, consider troponins

* Interview and examine the patient
  - Does patient have history of a-fib?
  - Shortness of breath or chest pain?
  - New abdominal pain or worse abdominal exam?
  - Blood soaked dressing or fresh blood in the JP?

* Possible etiologies / treatments:
  - Hypovolemia: Low UO, low BP, high JP output → fluid bolus, +/- blood transfusion if Hct low
  - Pain: Patient also hypertensive → adequate pain control
  - Medication withdrawal: If patient was on pre-op beta blocker
  - Rapid A-fib
    - If BP ok, metoprolol 5mg push. May repeat twice every 3-10 minutes.
    - If borderline or low blood pressure, call TR or cardiology consult for input re: cardioversion, and consider diltiazam 0.25mg/kg slow push (may repeat) or 150mg amiodarone load over 10 min
  - Sepsis/anastomotic leak? New a-fib may be an omen.
  - Pulmonary embolism
    - If no other obvious etiology and renal function ok, PE may be ruled out with CT Angio
* Recheck the vitals manually. Look for associated abnormalities.
* Is the patient stable or unstable?
* Review intra-operative fluid losses and replacement: is the patient behind on fluids?
* Review medications: hold BP meds and narcotics
* Check labs. An unexpectedly high creatinine or hematocrit might reveal hemoconcentration; a very low hematocrit may signal bleeding
* Start with a 1L normal saline/plasmalyte bolus (as fast as possible healthy patients)
* Consider steroid withdrawal
* Alert senior if you think it is a significant problem
27 | POST-OP PROBLEMS: HYPERTENSION

* Stable or unstable? If unstable, call for help while starting to address the problem

* Recheck and get a full set of vitals

* Ask and examine patients for signs of end-organ affects: vision changes, headaches, AMS, focal neurologic deficits

* Possible etiologies:
  - pain/anxiety
  - changes in medication/anti-hypertensives held*
    (clonidine withdraw, missing home meds are notorious)
  - withdrawal

* Treatments:
  - go slow, if blood pressure is extremely elevated
  - treat underlying issue (pain medication, anxiolytics)
  - metoprolol 5mg IV push stat if not bradycardic
  - hydralazine 10mg IV stat if not tachyCARDIC
  - enalapril 2.5mg IV stat
  - all of these can be given multiple times, but give them time to work otherwise the patient will "bottom out"

* Consider calling medical teaching resident on call for help with management

* If AMS or focal neurologic deficits present, consider getting nonconstrast CT Head and calling stroke team

* Does someone else need to know immediately or in AM?
* **A for Airway!** If the patient cannot protect their airway page Anesthesia stat – you can always decide not to intubate but better to have help on the way.

* Postop delirium often has an ORGANIC cause – find it!

* Check vitals, O2 Sat, fingerstick

* Hold narcotics and psych meds—if opioid overdose is a possibility, have naloxone ready.

* Check pupils, check for focal neurologic deficits—did the patient have a stroke? Consider CT head and call stroke team (p 3886).

* Check EKG—is the patient having an MI or PE?

* Check abdominal exam—AMS may be first sign of sepsis from anastomotic leak or perforated stress ulcer! Consider a portable upright CXR or lateral decubitus film to r/o free air.

* If any concern for low saturation check ABG—PE may present with AMS!

* Send off basic labs: CBC, Chemistry, Troponin if elderly or with other cardiac risk factors, Type & Screen if expired

* If fever/high WBC also present, send off blood cultures.

* Consider psych consult if no etiology apparent.

* **Notify your chief!**
* If your patient is poorly responsive or unresponsive, ask for help!

* Confirm DNR/DNI status

* Call/ask nurse or someone else to call Team 7000 (47000) and anesthesia stat. During the day have a team member notify the chief resident immediately. Overnight the senior surgical resident on call should be notified immediately.

* Call for the ambu-bag and crash cart to be brought into room

* If you are the first one there and CPR is indicated, do it!

* **Airway** ➔ Start with chin-lift, jaw-thrust, ventilate the patient with the ambu-bag and be sure you are getting adequate chest rise, have oral airway in place, suction as needed

* **Breathing** ➔ You may have an RN bag the patient as long as you know the airway is patent

* **Circulation** ➔ If no pulse begin compressions, make sure patient has good IV access and bolus NS, get patient hooked up to a defibrillator

* Send off full set of labs including troponin and T&S

* Code team will help you with medication administration
Learning to cope with patient deaths and families of the deceased patients is one of most difficult tasks of residency. If they happen when you are on call, there are several things that must be taken care of.

1. **Notify your chief resident.** He or she may call the attending, or have you call the attending directly. Either way, the attending must be notified immediately. (If it is not your primary patient, alert the primary team!)

2. **Clarify who will be calling the family** to notify them about the death and ask for permission for autopsy.

3. **All deaths within 30 days after surgery** must be then referred to the Medical Examiner (212-447-2030). If the ME accepts the case, they will complete the death certificate.

3. If the medical examiner rejects the case, or the death has not occurred within 30 days after surgery, you must complete the online death certificate. You can get help completing this online form by paging the nurse manager on call or going to medical records. You must know the cause of death—if you need help, call the ME and present the case and they will recommend an “official” cause of death.

The online program DAVE requires:
- Login ID
- Password
- Fingerprint
* Autopsy should be requested for all patients and should be discussed with the family in an appropriate manner.

* Autopsies are performed either by the Dept of Pathology at Mount Sinai or by the NYC Medical Examiner (ME).

* Clarify with your chief who should ask the next of kin for autopsy consent.

* Autopsy consent forms are available on PatientWorks.

* Be clear about the benefits of autopsy:
  (1) providing family & medical team knowledge about all the factors that may have contributed to patient's death
  (2) sense of closure for the family
  (3) potential knowledge about illnesses that may affect other family members.

* Autopsies can generally be performed within 24-48 hrs and do not typically delay funeral arrangements. They also do not significantly alter the external appearance of the patient.

* Overnight, a completed autopsy consent form goes in the chart which goes to Medical Records the next morning.

* You should page pathology on-call to alert them to an expected autopsy.

* Funeral home and hospital morgue communicate re: transfer of the deceased.
32 | DISCHARGE PLANNING: SW & PT

* Start early!!! It will take some time to place some patients (ie. patients requiring IV Abx, TPN, wound vac)
* Talk to patient and family on admission to assess living situation, mobility prior to surgery/ hospitalization
* Clarify with chief resident and attending anticipated discharge dates and patient needs so you can pass on information to SW
* Round with social work every day and follow up throughout the day to make sure paperwork is completed

**Visiting Nurse Services**
- If a patient needs wound care, drain care, IV antibiotics, TPN, lovenox injections, etc. they will need VNS
- Home Health Aid: Patients have to qualify for this if they need assistance at home. HHAs help with things like cleaning, cooking, etc. They do not perform medical tasks.

**Physical Therapy**
- Place an inpatient PT consult through Epic
- Follow up to see what PT recommends re: no needs vs home PT vs acute rehab vs subacute rehab

**Forms to know about and fill out early:**
- **Interinstitutional Transfer Form (ITT):** for patients going to rehab/nursing facility after discharge
- **Briggs Form:** for patients who need VNS or home PT
- **KCI form:** for patients who need home wound VAC, takes ~2 days to arrive
Paging at Sinai: 41300 / Paging at Elmhurst: 41908

* Enter the extension you are at followed by (*) and your pager number (i.e. 45533*3602). When you page someone who may not be in the hospital, only page to an extension starting with 4 so that they can call you back directly.

* You can text page on www.amion.com BUT the text pages will not be forwarded. To forward your pager when in the OR or unavailable dial: 41200, 1, 7, covering pager number, #.

* DO NOT text-page important information. Remember, if you don’t hear back after a text page, **do not assume** the person got the message!! (Conversely, always text “ok” to acknowledge that you received a message.) If your question requires a response, speak to the person directly. If nurses text page you about patients, call them back to discuss the issue and remind them that you do not always get text messages immediately (i.e. if you are scrubbed). The same goes for other services following your patients. **Do not accept consults via text page!** Call the team back and ask them to tell you about the patient over the phone. Alert Dr. Divino if this happens.

* **When calling a consult, ALWAYS CLARIFY** with your your chief/attending who exactly is to be called. Sometimes you will be directed to call the teaching service for that specialty (i.e. the pulmonary service); other times you will have to directly page a specific private attending, or their covering partner, in that specialty for the consult.
34 | WEBSITES

Attending license numbers → www.health.state.ny.us/professionals/doctors/conduct/license_lookup.htm

Call schedule for all services → www.amion.com
  *mssurg* for surgery
  *mssm* for most non-surgical specialities
  *msmed* for medicine residents
  *ehc* for Elmhurst rotators

Case logs → www.acgme.com

Evaluations and work hour logs → www.new-innov.com

Levy Library, access to online textbooks, UpToDate → http://icahn.mssm.edu/about-us/services-and-resources/levy-library

MSH intranet page → http://intranet1.mountsinai.org

Resident homepage → www.mssurg.com

SCORE curriculum → http://portal.surgicalcore.org
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36 | DICTATION PROCEDURES

To dictate a report at Sinai:
From in-house phone: 89889  From outside: 212.659.9889
Enter facility ID: 89
Enter your 5 digit dictation code
Enter patient's 7 digit medical record number
Enter work type: 1=inpatient, 2=ambulatory)
Begin dictating at the tone
1=Pause, 2=Record, 3=Rewind & Play
4=End of file & Record, 5=Play, 6=Next dictation,
7=Beginning of file & Play, 8=Insert, 9=Long rewind
*=End call, 0=Help

At Elmhurst:
From an in-house phone dial 45061
Enter your dictation code#, MRN#, 7#, start dictating.

37 | COMPUTER PROGRAMS

**EPIC**: Used to view patient data, enter orders, update the
list, write daily progress notes

**OR Web Schedule**: OR schedule (Access through
"Applications-Web-Based" link on main intranet page, use
“Future date” function for updated schedules)

**PACS**: Radiology images

**PatientWorks**: Used to print forms like consents, progress
notes, pre-op checklist. Only prints on specific printers.

**Quadramed**: Elmhurst program for orders and patient data
**ALC**: Alternate level of care, only at Elmhurst. This means the patient does not need to be seen every day by the team. Used primarily for social admits or completely stable patients awaiting placement.

**AOD**: Administrator on duty, at Elmhurst. This is person available 24/7 who helps take care of disputes & delays in patient care and also witnesses telephone consents.

**Blue-slip**: Call the ER (x43611) and ask them to notify you when the patient arrives in the ER. Not reliable.

**CCU**: Cardiac care unit (5E)

**CSIU**: Cardiac surgery intensive care unit (5C)

**CTICU**: Cardiothoracic intensive care unit (6C)

**FPA**: Faculty Practice Associates. All full time faculty have their clinic/offices in the "FPA" located at 5 E. 98th Street.

**HMP**: Hospital Medical Practice. The non-teaching medicine services, run by attendings/hospitalists/NPs.

**IDP**: Implement discharge plan. An order in Epic that should be written the day before a patient is/may be discharged. Allows patients the chance to appeal their discharge.

**IMA**: Internal Medicine Associates

**LTM**: liver transplant monitor, includes chem10 + LFTs

**MAR**: medical admitting resident

**MARS**: MICU acute response service. They will come evaluate a patient ASAP for potential intervention or admission to the medical ICU.

**ME**: medical examiner

**MICU**: Medical intensive care unit

**NSICU**: Neurosurgical ICU
PACU: Post anesthesia care unit, where patient's go post-op and stay overnight if waiting for a stepdown or ICU bed.

Phase II: Where ambulatory patients at Sinai go after PACU and prior to discharge home. Located on GP2.

Pink-slip: Go to OR/call OR desk to book for an emergency/add on case at Sinai or Elmhurst. As in, "pink slip the appy." Actually a pink piece of paper at Elmhurst.

POMAF: PreOp Medical Assessment Form: required for all ASA 3+ nonemergent inpt cases. PMD/TR completes

PT: physical therapy

RICU: Respiratory intensive care unit

SAR: Sub-acute rehab (a recommendation from PT)

Social Pool: The medicine service at Elmhurst can distribute patients to other services who are medically ready for discharge but cannot leave for social/placement reasons.

SICU: Surgical ICU

SNSS: Surgical Nutrition Support Service (Line service/TPN)

SQH: Subcutaneous heparin

Step-down: A 4 bed room with 2 nurses. Between ICU and regular floor beds. General surgery/vascular stepdown is on 10E.

Team7000: A code

TCC: Terrance Cardinal Cooke, a nursing home that accepts many otherwise difficult to place patients (dialysis, wound vacs, TPN, etc)

TR: Teaching resident, PGY3 medicine resident on-call for curbsides or consults re: any medical issues, including general medical clearance.

VNS: Visiting Nurse Service. Patient who are discharged home and need nursing care at home (i.e. wound care, dressings, ostomies, etc).
Main Hospital: 212.241.6500
To page: 41300, To forward pager or record name: 41200
Long distance code for Department of Surgery 4844588

ER / Blue-slip 43611
Main OR Control Desk / Pink-slip 41990 / 37894 / 37896
Add-on Cases: 4CASE    OR scheduling: 81210
Anesthesia Team Leader p2875
Bedboard 45030, 47461
Inter-hospital transfer 46467

**GP 3 OR Numbers**
GP2 Admitting Area 47778
GP 2 pre-op area 46448
Phase two 47742
GP3 Holding Area 41991/ 43402 / 34197
GP3 PACU 41992 / 41993/ 37900

**Cardiac Cluster** Communication Desk 46257 / 40244
GP1 37943    GP4 45165
GP2 37944    GP22 40469
GP3 37947    GP23 37955

**Orthopedic Cluster** Communication Desk 42007
GP8 43281    GP18 37964
GP9 37960    GP19 37965
GP10 37963

**West Tower** Communication Desk 45525 / 45523
GP11 39657    GP15 39647
GP12 39655    GP16 39661
GP14 39651    GP17 39659
**East Tower** Communication Desk 41998
GP5 37937       GP20 37935
GP6 37938       GP21 37936
GP7 43280       GP24 30095

**Annenberg 6**
Holding Area 45593 / 39010
PACU 45987       A6 43267
A1 43272A7 43266
A2 43264A8 48040
A3 43265A9 47937
A4 48082A10 43270
A5 43268A11 45471   A12 40926

**Annenberg 7**
PACU 43277       A20 30220
A18 33823       A21 30994
A19 32731       A23 33590

**Floor Numbers**
SICU (6E) 45111       MICU (5W) 45721
CTICU (6C) 47955       CSIU (5C) 47344
CCU (5E) 47222       NSICU (Ann8) 42100
P5 45426       KCC3 42999
6W 45533       9C 47944 (TICU 49764)
7W 47918       9E 47935
7C 47918       10W 45444
7E 45544       10C 47921
8W 45558       10E 43595
8C 47923       11W 45826
8E 47939       11C 45566, 47927
9W 45422       11E 44259

10E Stepdown #1 (Rm 323/324) 46312
10E Stepdown #2 (Rm 315/316) 41787
10E Stepdown #3 (Rm 301/302) 33363
Radiology
Radiology Resident On-Call (Call to prioritize scans) p1490
Main Radiology / X-Ray 47401 / 48422
Film Library 48424
CT 47412, CT Reading Rooms: 47928, 47991, 30048, 30087
ER CT 47606
US 47431, US Reading Rooms: 45750, 45751, 39806, 39807
MRI 48775, MRI supervisor p7905, MRI reading 41953
Nuclear Medicine 46611
IR Front Desk 47409, IR Recovery Room 42797
Echocardiograms 41718
Vascular Lab 49622

Labs
Main Labs (Call first) 4LABS
Central Accessioning 88145
Chemistry Lab 88134
Hematology Lab 88135
Microbiology Lab 88162
Pathology accessioning 45617

Other Important Numbers
Acute Rehab Consult 31313
Blood bank 46101
Cardiac Cath Lab 45881
Central Supply 46732
Diabetes Consult p917GLUCOSE
Dialysis 48081
ENT Consult p2510
Endoscopy 46277
Housekeeping 46595
ID Approval p9407
Infection Control 89450
Line Service/TPN (6E) 37393 / 41545, p1872
Ostomy Nurse Room 47231
Pain Service- Acute 646-592-0145, p2738
Pain Service- Chronic 646-592-0084, p0329
Palliative Care p9399
Pathology Department 47363, Accessioning 45617
Pegasys Beds 43490
Pharmacy - Main 47714
Pharmacy - 6C (supplies 6W, 7C, 9E, SICU) 41806
Pharmacy - 8C (supplies 8C, 8E, 9C) 41507
Pharmacy - 11C (supplies 10E, 11W) 41510
Physical Therapy Consult (also place order in Epic) 42363
Medical Examiner 212.447.2030
Morgue 47376
Needle stick Coordinator p4118
Stroke Team p3886
Social Work 46800
Specialty clinic (i.e. surgery)- 88554
Surgery Department 45871
Teaching Resident (Medical) p2125
TPN Pharmacy 46601
Translator Phone: 800.264.1552 (access #828099)
Transport 44443
Wound VAC machines 44PEP (Patient Equipment Pool)

______________________________

Team Room Numbers
Team III 47154
Team IV 47357
Team V 41479, 42609
Surg Onc 38498 & 45196
Vascular 31526, 48189 & 31527
Elmhurst 718-334-2818
Surgeons must be very careful
When they take the knife!
Underneath their fine incisions
Stirs the Culprit—Life!

- Emily Dickinson