Crystal Run Healthcare
155 Crystal Run Road
Middletown, NY 10941
845•703•6999
www.crystalrunhealthcare.com

FAX COVER SHEET

To: ORMC-Endo

From: Aimee Medina

Company:

To Fax Number: 8453331041

Fax Reference ID: AME5E61287F236B

Date: 3/5/2020 4:27:38 PM

# of pages [incl. cover]: 6

Notes/Comments:

From Fax Number:

Sender Mailing Address: 155 Crystal Run Road
Middletown, NY 10941

ORANGE REGIONAL MEDICAL CENTER SURGICAL BOOKING AND PERIOPERATIVE ORDERS SHEET	Completed form must be faxed to the ORMC Scheduling Office Inbound 845-333-1041	Patient Label
PATIENT NAME: Stuart Frummer	DOB: 3-26-47 SEX: M	Diagnosis: pancreatic cyst
ADDRESS: 283 Gabriel Rd	Surgeon: Mahmood	Assistant:
Cochecton NY 12726	CPT CODE 43242	ICD 10 CODE K86.2 PRE-CERT #:
HOME NUMBER 845-583-4626 CELL NUMBER ———	INSURANCE CO. Medicare	INSURANCE ID NUMBER
PROCEDURE DATE 4-3-20 PROCEDURE LENGTH 1hour ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT		
PROCEDURE ORDER FOR CONSENT:		
EGD/EUS with possible FNA		

IS PATIENT BEING SCHEDULED FOR BLOODLESS SURGERY ☐ YES ☐ NO PATIENT IS ERAS ☐ YES ☐ NO

TYPE OF ADMISSION: ☑ ORMC ☐ POB ☐ OBS ☐ SDS ☐ 23hr. ☐ INPATIENT ☑ ENDO

PATIENT SPECIFIC NEEDS: ☐ FACILITY/GROUP HOME ☐ FORENSIC PATIENT ☐ LANGUAGE LINE ☐ SPECIAL NEEDS / should not be first case

PATIENT OR FAMILY MEMBER HAS HISTORY OF MALIGNANT HYPERTHERMIA ☐ YES ☐ NO

ANESTHESIA COMPLICATIONS / DIFFICULT INTUBATION ☐ YES ☐ NO

☐ PACEMAKER ☐ AICD VENDOR _____ SPECIAL EQUIPMENT _____

☐ Cell Saver ☐ C-Arm ☐ Oxygen ☐ IMPLANT / EQUIPMENT FORM ☐ IMPLANT RECALL (Specify) _____

PRE-SURGICAL TESTING APPOINTMENT May we leave a message? ☐ Yes ☐ No PRIMARY DOCTOR _____

☐ PST MEPS being done at ☐ ORMC ☐ CRHC ☐ MEPS Consultation by Dr. _____ Diagnosis _____

☐ PST Nurse only – patient NOT on insulin or anticoagulant

☐ PST Phone Assessment only – (does not stratify – NOT on insulin or anticoagulant)

DIABETIC ☐ Yes ☐ No ON INSULIN ☐ Yes ☐ NO ON ANTICOAGULANT ☐ Yes ☐ No Type _____ HISTORY SLEEP APNEA ☐ Yes ☐ No

PRE-SURGICAL MEDICAL EVALUATION

Surgical Risk: ☐ Minimal ☐ Low ☐ Intermediate or High Health Risk: ☐ A ☐ B ☐ C ☐ D

☐ Medical /Cardiac Consultation by Dr. _____ Anesthesia Consultation Requested ☐ Yes ☐ No

PRE-SURGICAL TESTING ORDERS ☐ OTHER _____

☐ T & S # OF UNITS _____ ☐ CBC ☐ BMP/CMP ☐ PT INR ☐ PTT ☐ MSSA/MRSA screen culture ☐ U/A ☐ EKG ☐ CXRAY ☐ C-SPINE

☐ KNEE X-RAY *(circle one)* LEFT RIGHT ☐ HIP X-RAY *(circle one)* LEFT RIGHT FOR ERAS Patients ☑ follow ERAS protocol & Prehab as indicated

PERI-OPERATIVE ORDERS FOR ERAS PATIENTS ☑ follow ERAS protocol FOR PATIENTS WITH DIABETES ☑ follow Perioperative Insulin Protocol Order Set

☐ Blood Glucose Monitoring Test Upon Arrival to Pre-Op ☑ Urine Pregnancy Test Upon Arrival to Pre-Op age 12-55 unless H/O TAH or BTL

☐ LR at 100ml/hr ☐ NS at 100ml/hr ☐ LR at KVO ☐ Other IV fluid _____ ☑ Saline lock with NS flush

☐ KUB X-Ray upon arrival to Pre-Op ☐ Intraop Venodyne ☐ Intraop Foley ☐ Additional Orders _____

ALLERGIES ☐ None Known ☐ LATEX ☐ METAL ☐ OTHER _____

ALLERGIC REACTION _____

MEDICATIONS PREOPERATIVELY FOR ERAS Patients ☑ follow ERAS medication order protocol

☑ FOR TOTAL JOINT Patients follow Total Joint Protocol ☐ Cefazolin (Ancef) _____ gm IV ☐ Surgeon reviewed PCN allergy–benefit outweighs risk

☐ Vancomycin _____ mg IV ☐ Gentamicin _____ mg IV ☐ Clindamycin _____ mg IV ☐ Metronidazole _____ mg IV or PO *(CIRCLE ONE)*

☐ Levofloxacin _____ mg IV or PO *(CIRCLE ONE)* PEDIATRIC DOSING ONLY _____ mg/kg IV

Additional Pre-operative orders _____

PHYSICIAN SIGNATURE /PRINTED NAME: SYED MAHMOOD TIME: 2:00 DATE: 3-5-2020

STAFF SIGNATURE/PRINTED NAME: K Breitenbach / K Breitenbach TIME: 2:00 DATE: 3-5-2020

Crystal Run Healthcare Physicians LLP
155 Crystal Run Road
Middletown, NY 10941-4028
USA
(845) 703-6999

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
Frummer, Stuart	145239	###-##-5209	03/26/1947	English	M

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)	ETHNICITY
283 Gabriel Rd		Not Hispanic or Latino

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	SECONDARY HOME PHONE	RACE
Cochecton, NY 12726	(845) 583-4626			Caucasian

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE
Barbanel MD, Eric W	Colvin MD, Rachel F		

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	SECONDARY HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
Medicare Part B	6V61AT8TR90	
NAME OF INSURED	GROUP#	
Frummer, Stuart		
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
PO Box 100	$0.00	
CITY, STATE ZIP	DEDUCTIBLE	
Yorktown Heights, NY 10598-0100		
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE
SELF		

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#		
AARP	03329701711		
NAME OF INSURED	SSN#	BIRTHDATE	GROUP#
Frummer, Stuart			
ADDRESS OF INSURANCE COMPANY	COPAY AMT		
PO Box 740819	$0.00		
CITY, STATE ZIP	DEDUCTIBLE		
Atlanta, GA 30374-0819	$0.00		
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE	
SELF			

*All returned checks are subject to a $25.00 check fee.

I authorize the release of any medical or other information necessary to process claims. I also authorize government benefits to the provider who accepts assignment and authorize payment to the physician/supplier for services provided. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

We want you healthy.
Crystal Run Healthcare

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Patient:	Stuart Frummer
Date of Birth:	03/26/1947
Date:	03/04/2020 05:47 PM
Historian:	self
Visit Type:	Consult
Document Type:	Consult Note

Rachel Colvin MD
30 Hatfield Lane
Suite 208
Goshen, NY 10924-6768

Re:	Stuart Frummer
DOB:	03/26/1947
Age:	72 years
Gender:	Male

I had the pleasure of participating in the care of your patient at request for a consultation.

This 72 year old male.

PAST MEDICAL/SURGICAL HISTORY (Detailed)

Disease/disorder	Onset Date	Management	Date	Comments
cardiac stents	2008	on ASA and Plavix - Gotsis		
diverticulitis 3 xs				
excision left thigh mass - basal cell ca 1.9 cm		margins free - 8/18/11 - ormc - arguelles		
kidney stones				
left thigh reexcision		local rotation flap		

9/1/11 arguelles/sacks	closure- path pending.
R hand surgery	
SCC on back	surgical removal 2014
t+a	
Urolithiasis	
volvulus with perf	hemicolectomy with ilistomy 2019 colostomy reversal 2019
asthma - hosp, no intub	

GYNECOLOGIC HISTORY:
Date of last mammogram: 07/18/2013.

Medications *(Started, Stopped or Renewed this visit)*

Started	Medication	Directions	Instruction	Stopped
11/29/2019	ADVAIR DISKUS 250-50MCG/DOSE AEPB	INHALE ONE PUFF BY MOUTH TWICE A DAY APPROXIMATELY 12 HOURS APART		
07/24/2019	Aspir-81 81 mg tablet,delayed release	take 1 tablet by oral route every day		
02/11/2020	baclofen 10 mg tablet	take 1 by Oral route 3 times every day as needed		
02/11/2020	Calcium 500 500 mg calcium (1,250 mg) tablet	take 1 by Oral route 3 times every day		
	Centrum Silver 500 mcg-250 mcg Chewable Tab	Take one tablet by mouth daily		
02/11/2020	Flomax 0.4 mg capsule	take 2 Tablet by Oral route every day GENERIC		
02/11/2020	Fosamax 70 mg tablet	take 1 tablet by oral route every week		
02/11/2020	Inderal LA 60 mg capsule,extended release	take 1 Capsule by oral route every evening		
02/11/2020	Neurontin 300 mg capsule	take 1 capsule by ORAL route every day q hs		
01/17/2020	SIMVASTATIN 20MG TABS	TAKE ONE TABLET BY MOUTH EVERY EVENING		
01/17/2011	Vitamin D 2,000 unit Cap	2 by mouth daily		

Allergies

Ingredient	Reaction (Severity)	Medication Name	Comment
NO KNOWN			

ALLERGIES
Reviewed, no changes.

Family History (Detailed)

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death
				No family history of Diabetes mellitus		N
				No family history of Coronary artery disease, premature		N
				No family history of Stroke		N
				No family history of Cancer -colon		N
				No family history of Cancer -		N
				No family history of Cancer -prostate		N
Father		N		cad at 65, htn, inc chol		N
Mother		N		healthy		N

Social History: (Reviewed, updated)

Tobacco use reviewed.
Preferred language is English.
The patient does not need an interpreter.

EDUCATION/EMPLOYMENT/OCCUPATION

Employment	History	Status	Retired	Restrictions
	model maker			

MARITAL STATUS/FAMILY/SOCIAL SUPPORT
Currently married.
Previously divorced one time.
CHILDREN
Has children: 1 daughter(s).
Tobacco use status: Current non-smoker.
Smoking status: Never smoker.

SMOKING STATUS

Type	Smoking Status	Usage Per Day	Years Used	Total Pack Years
	Never smoker			

TOBACCO/VAPING EXPOSURE
No passive smoke exposure.
ALCOHOL
There is no history of alcohol use.