Ricciardi, Anthony Jr.

ORANGE REGIONAL MEDICAL CENTER

FAX TRANSMISSION

Date: 1/4/2010	Time: 1710	From:
Dr. Stead/Dr. Koulova Fax #: 845-294-1669		Cancer Center Outpatient Infusion Center Phone: 845-333-1150 Infusion InBound Fax: 845-333-9400

Number of pages, including this coversheet: 3

Information Transmitted:

Pls sign consent of A Ricciardi Jr (11/4/67) & give back

ORANGE REGIONAL MEDICAL CENTER

Informed Consent for Blood Transfusion and/or Blood Component Administration for Non-Surgical Patients

Ricciardi, Anthony Jr.
Sex:M DOS:11/11/1967 52 y.o.
MRN:386748 DOS:12/27/19
Acct: 5081491827
CSN: 12817240

I, _____ or _____, acting on the patient's behalf, have been advised by
Parent, guardian, or representative

Dr. Kondova, that I need or may be in need of a blood transfusion and/or blood products during my hospitalization or course of treatment.

I have been informed of the reasonable benefits and potential risks of the proposed transfusion.

I understand that the blood of the donor is tested and screened, and precautions are taken by my physician prior to a transfusion. I also understand that despite the measures that are taken, I still may be subject to ill effects as a result of receiving blood and/or blood products.

I have been informed about what may happen if I decide not to have this transfusion, including the reasonable medical alternatives, if any, and their common foreseeable risks and benefits. I understand that along with my physician and his/her assistants, other authorized hospital personnel may be involved in the administration of my blood and/or blood products.

I acknowledge that I have been given the opportunity to ask questions and I am satisfied with the explanation I have been given regarding my need for blood and/or blood product transfusion and accept the transfusion.

Date/Time	Patient's/Guardian/or Representative Signature	Print Name
12/27/19 0616 AM PM		Anthony C Ricciardi Jr
12/27/19 0816 AM PM	Witness Signature	ROSALINDA YAP
12/28/19 AM PM	Physician Signature	Kondova L.

Telephone Consent
Verbal authorization for the procedure(s)/treatment(s) in paragraph one above was obtained from the consenting party named below, who has stated that he/she has authority to consent on behalf of the patient following an explanation of the information in paragraph two above.

Date/Time	Consenting Signature	Print Name
AM PM		
AM PM	Witness Signature	Print Name

☐ Mark this box if interpreter was involved _____ (Interpreter ID #)

FAXED 12/28/19 0838

ORANGE REGIONAL MEDICAL CENTER
Physician Order Form

Riesiardi, Anthony Jr.
Sex:M DOB:11/11/1987 32 y.o.
MRN:386740 DOS:2/04/20
Acct:8081537782
CSN: 13006303

DO NOT USE ABBREVIATIONS

U	MS	SC	QOD	QD	µg
IU	MSO_4	$MgSO_4$	SQ	SL	

Date & Time	Standing Order	**Dx:** Acid Reflux
2/4/20 1330	T.O. Dr. Kloulova / Amorella Administer Pepcid 20mg IVP daily PRN for c/o acid reflux Route IV infusion RBV 1330 Amorella	

Medications will be dispensed in accordance with the hospital formulary system

Prescriber Signature: [signature] Print Name: _____ Date/Time: 2/5/20 (5.3?)

Nurse Signature: _____ Print Name: _____ Date/Time: _____

☐ T.O. RBV Fax to Pharmacy ☐ Time Faxed: _____

ORANGE REGIONAL MEDICAL CENTER

Informed Consent for Blood Transfusion and/or Blood Component Administration for Non-Surgical Patients

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Sex:M DOB:11/11/1967 52 y.o.
MRN:386748 DOS:12/27/19
Acct: 5001491627
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Parent, guardian, or representative

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12/27/19 0816 AM PM Date/Time	Patient's/Guardian/or Representative Signature	Anthony C Ricciardi Jr Print Name
12/27/19 0816 AM PM Date/Time	Witness Signature	ROSALINDA YAP Print Name
12/28/19 AM PM Date/Time	Physician Signature	Kowlora Print Name

Telephone Consent
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_____ AM PM Date/Time	Consenting Signature	Print Name
_____ AM PM Date/Time	Witness Signature	Print Name

☐ Mark this box if interpreter was involved _____ (Interpreter ID #)

FAXED 1-28-20 0838

ORANGE REGIONAL MEDICAL CENTER
Physician Order Form

Riccardi, Anthony Jr.
Sex:M DOB:11/11/1967 52 y.o.
MRN:386740 DOS:2/04/20
Acct: 5001537792
CSN: 13006303

DO NOT USE ABBREVIATIONS

U	MS	SC	QOD	QD µg
IU	MSO_4	$MgSO_4$	SQ	SL

Date & Time

Standing Order

Dx: Acid Reflux

2/4/20

1330 T.O. Dr. Koulova / Antonella

Administer Pepcid 20mg IVP daily prn for c/o acid reflux

Write in admission

(RBV) 1330

Antonella

Medications will be dispensed in accordance with the hospital formulary system

Prescriber Signature: _____ Print Name: _____ Date/Time: 2/10/20 8 p.m.

Nurse Signature: _____ Print Name: _____ Date/Time: _____

☐ T.O. RBV Fax to Pharmacy ☐ Time Faxed: _____