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FAX COVER SHEET

To: ORMC

From: Maloney, Noreen

Company:

To Fax Number: 3331041

Fax Reference ID: NMA5E4441D8A960

Date: 2/12/2020 6:19:58 PM

# of pages [incl. cover]: 2

Notes/Comments:

DOS 03/05

Dr. Fiorianti

Please call patient to schedule PST MEPS appt.

Thank you

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: Neil Miller	**DOB:** 7/27/55 **SEX:** male	**Diagnosis:** Atherosclerosis with claudic	
ADDRESS: 106 Chippewa Rd Shohola, PA 18458	**Surgeon:** Fonash	**Assistant:**	
	CPT CODE 36246	**ICD 10 CODE** I70.23	**PRE-CERT #:**
HOME NUMBER 570-409-6189 **CELL NUMBER** 718-840-9918	**INSURANCE CO.** MEDICARE	**INSURANCE ID NUMBER** 6RØ1TH3TW16	

PROCEDURE DATE 3/5/20 **PROCEDURE LENGTH** 1.0 ☐ LEFT ☒ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT:

Right lower Extremity Angiogram with bilateral runoff and possible balloon angioplasty and Stenting

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 NOT AT CRHC

☒ 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 Plavix-ASA = contrave

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

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

Meps cardio

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 Penicillin

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: _____ **TIME:** 5:00PM **DATE:** 2/12/20

STAFF SIGNATURE/PRINTED NAME: _____ **TIME:** 5:00PM **DATE:** 2/12/20

543012 N. Maloney 703-6477