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FAX COVER SHEET

To: ormc

From: Brundage, Donna

Company:

To Fax Number: 3331041

Fax Reference ID: DBR5E44252ECBE3

Date: 2/12/2020 4:17:44 PM


of pages [incl. cover]: 3

Notes/Comments:

From Fax Number:

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

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 ORANGE REGIONAL MEDICAL CENTER SURGICAL BOOKING AND PERIDPERATIVE ORDERS SHEET		Completed form must be faxed to the ORMC Scheduling Office Inbound 845-333-1041		Patient Label	
PATIENT NAME: WILLIAM PEDERSON		DOB: 05/05/50	SEX: M	Diagnosis: Abdominal Pain	
ADDRESS: 92 COTTAGE ST APT 2 MIDDLETOWN, NY 10940		Surgeon: SANDEEP MALHOTRA		Assistant:	
HOME NUMBER 845-343-7939		CELL NUMBER 845-649-4731	CPT CODE 47562 44970	ICD 10 CODE K10.11	PRE-CERT #:
INSURANCE CO. UNITED		INSURANCE ID NUMBER			
PROCEDURE DATE 3/17/20 PROCEDURE LENGTH <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BILATERAL <input type="checkbox"/> TRIAL PRODUCT					
PROCEDURE ORDER FOR CONSENT: ROBOTIC POSSIBLE OPEN CATHETERIZATION AND APPENDICITOMY					

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 WIDETHEW HISTORY SLEEP APNEA ☐ Yes ☒ No

PRE-SURGICAL MEDICAL EVALUATION STOP 5d before Surgery

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

☒ Medical / Cardiac Consultation by Dr. Amr. Taw. 3/2/20 @ 3:45 PM Anesthesia Consultation Requested ☐ Yes ☒ No

HEMATOLOGY Mar 6/11 - 2/26/20 @ 3:00pm

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 OrderSet

☐ 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) 2 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: S. Malhotra SANDEEP MALHOTRA TIME: 3:40 PM DATE: 2/12/2020

STAFF SIGNATURE /PRINTED NAME: Shirley P. Lopez TIME: 4:12 PM DATE: 2/12/20

