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

FAX COVER SHEET

To: ORMC (Admission Change)

From: DePoo, Tayjwatee

Company:

To Fax Number: 8453331041

Fax Reference ID: tad5E4127D29429

Date: 2/10/2020 9:52:12 AM

# of pages [incl. cover]: 2

Notes/Comments:

From Fax Number:

Sender Mailing Address: 155 Crystal Run Road

Middletown, NY 10941

Admission Change

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: Rosalia Guerrero	DOB: 3-1-68	SEX: Fe	Diagnosis: Pelvic pain Fibroid Uterus
ADDRESS: 64 East Ave.	Surgeon: Manan Shah MD		Assistant: Deborah Spencer, MD
Middletown, NY 10940	CPT CODE 58571		ICD 10 CODE D10.2, D25.9 / PRE-CERT #:
HOME NUMBER 862-600-1682 / CELL NUMBER	INSURANCE CO. Affinity		INSURANCE ID NUMBER

PROCEDURE DATE 2-13-20 PROCEDURE LENGTH ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT: Robotic Assisted Total Laparoscopic Hysterectomy, Bilateral Salpingectomy, Exam under Anesthesia, possible Laparotomy

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

TYPE OF ADMISSION ☒ ORMC ☐ POB ☐ OBS ☐ SDS ☒ 23hr. ☐ INPATIENT ☐ ENDD

PATIENT SPECIFIC NEEDS: ☐ FACILITY/GROUP HOME ☐ FORENSIC PATIENT ☒ LANGUAGE LINE Spanish ☐ 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 Appt - 2-7-20 at 3:00pm

☐ 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 ☐ UA ☒ 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 Diclofenac Sodium

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: [signature] Manan Shah, MD TIME: 4:00pm DATE: 1-27-20

STAFF SIGNATURE/PRINTED NAME: [signature] Seathes, K Canovan TIME: 3:55pm DATE: 1-27-20

Faxed 10 De