Crystal Run Healthcare
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FAX COVER SHEET

To: ORMC

From: Noreen Maloney

Company:

To Fax Number: 3331041

Fax Reference ID: NMA5DBC2592865B

Date: 11/1/2019 12:31:06 PM

# of pages [incl. cover]: 7

Notes/Comments:

DOS 11/18

Dr. Judd

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:	DOB:	SEX:	Diagnosis:	
Rumsey, Irene	10/14/1967	F	MORBID OBESITY	
ADDRESS:	Surgeon:		Assistant:	
2606 Route 302	Seth Judd, MD			
Middletown, NY 10941	CPT CODE 43775		ICD 10 CODE E66.01	PRE-CERT #:
HOME NUMBER 914-443-1976	CELL NUMBER 914-443-1976	INSURANCE CO. MVP Healthcare	INSURANCE ID NUMBER 80058493400	

PROCEDURE DATE 11-18-19 PROCEDURE LENGTH 1 Hour ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT: Sleeve Gastrectomy, Diagnostic Intraoperative Gastroscopy, Lap Band Removal MSOpen Removal

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 GASTROSCOPE

☐ 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. Mathew 10/30/19 Anesthesia Consultation Requested ☐ Yes ☐ No

PST was left on 10/29/19

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

PERIOPERATIVE 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) ____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: Seth Judd, MD, FAS, FASMBS TIME: 1140 DATE: 11/1/19

STAFF SIGNATURE/PRINTED NAME: J. Maloney TIME: 12:20 DATE: 11/1/19

703 6474

PO scheduled 11/26 8:45

ORANGE REGIONAL MEDICAL CENTER

Physicians Orders

Patient Name: Irene Rumsey
DOB: 10-14-1967
DOS: 11-18-19

GASTRIC BYPASS/SLEEVE GASTRECTOMY SURGERY PREOPERATIVE ORDERS

Allergies: NKDA

☐ Witness the patient's consent for:
Laproscopic Roux-en-Y Gastric bypass surgery with intra-operative endoscopy and gastrografin swallow study.

☒ Witness the patient's consent for:
Laproscopic Sleeve Gastrectomy surgery with intra-operative endoscopy and gastrografin swallow study.

☒ Nothing by mouth.
☒ Weigh patient on admission.
☒ Consult respiratory – teach patient use of incentive spirometer.
☒ Attempt to have patient void on call to OR
☒ Venodyne placement Bilateral Lower Extremities in holding area.
☒ Intravenous fluids: Ce at 150 mL/hour to be placed upon admission.
☒ Pre-op finger stick Blood Glucose if patient has Diabetes.

PRE-OP ANTIBIOTICS:

☒ Ancef 2gm to be given in Operating Room.
☒ Other:

Heparin 5,000 Units SQ on call.

Physician Signature: _____
Print Last Name: JUDD
Date: 11-1-19 Time: 1148

Nurse Signature: _____
Print Last Name: Fentress
Date: 11-1-19 Time: 1200

ORANGE REGIONAL MEDICAL CENTER

Consent for Surgical/Invasive Procedures and Sedation

Pt. Label

RUMSEY, IRENE 10/14/67

I hereby give my consent and authorize: Dr. JUDD and those who he/she may designate as associates or assistants to perform upon me or the named patient the following operation/procedures:

LAP BAND REMOVAL, MEDIPORT REMOVAL

The nature, intended purpose, benefits, significant foreseeable risks, complications and consequences of such operation/procedure, as well as the alternatives if the above operation/procedure is not performed, have been explained and discussed with me by (Name of Physician) _____

I give permission with full knowledge and understanding thereof. I understand that medicine is not an exact science and that there is the possibility that the operation/procedure may not have the benefits or results intended. I am also aware that there are always risks and dangers to life and health associated generally with surgery, use of medication, medical procedures and treatments which can cause adverse consequences not ordinarily anticipated in advance, but I give this permission with full assent nevertheless.

It has been explained to me and I understand that during the course of the operation/procedure, unforeseen conditions may be revealed or encountered which necessitate surgical or other procedures in addition to or different from those contemplated. I therefore request and authorize the above named physician or his/her designees to perform such additional surgical or other procedures as are deemed necessary or desirable.

- I understand that the procedure may require that I undergo some form of sedation, which may have its own risks. Prior to my procedure my doctor will inform me of the course of sedation that is recommended (if any) along with its risks, benefits, discomforts, and potential complications.
- I consent to photographing, videotaping, televising or other observation of the operation/procedure/treatment as may be purposeful for the advance of medical knowledge and or education, with the understanding that my/the patient's identity remain anonymous and all photographs and videotapes remain the property of ORMC and/or the responsible physician.
- I consent to the presence of Vendors/Salespersons/Students during the procedure/operation.
- I consent to the administration of blood/blood components if deemed necessary. The Surgeon has explained to me the need for, risks of and alternatives to a blood transfusion if blood or blood components are needed.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the procedure(s) specified above.
I further grant permission for the use of such tissues and/or organs as it may be necessary to remove during the procedure, for purposes of pathological diagnosis and thereafter for the advancement of medical science and education, and their disposal, at this Hospital or at such other institution as this Hospital may designate.

11/1/19 (Date) 1200 AM PM (Time) _____ (Patient/Health Care Agent/Surrogate/Guardian Signature) Irene Rumsey (Printed Name) _____ (Relationship to Patient)

11/1/19 (Date) 1200 AM PM (Time) _____ (Witness Signature) KATIE KATZKY (Printed Name)

☐ Mark this box if telephone consent ☐ Mark this box if interpreter was involved. _____ Interpreter ID #

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the procedure, the alternatives, including not performing the procedure, as well as the risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

11/1/19 (Date) 1146 AM PM (Time) _____ (Signature of Physician/Appropriately Credential Practitioner Providing Explanation) JDa (Printed Name)

DOB: 10-14-67
DOS:

ORANGE REGIONAL MEDICAL CENTER

Label

Consent for Laparoscopic Sleeve Gastrectomy

1. I Irene Rumsey hereby authorize Dr. Seth Judd (person performing surgery or procedure) and his/her designated assistants to treat the above named patient by performing the following operation (s) or procedure(s) *Laparoscopic Sleeve Gastrectomy with intra-operative endoscopy, gastrografin swallow study, and possible laparotomy* for clinically severe obesity.

I understand there may be significant risks. These risks include possible death due to cardiac complications, deep vein thrombosis causing pulmonary embolism, and anastomotic leak.

2. It has been fully explained to me the purpose associated with the procedure as well as informing me of the expected benefits, attendant discomforts, risks that may arise, both during the procedure and the recuperation period and the possibility of each complication and risk associated with the procedure listed below:

Some possible risks and complications are but are not limited to:

- injury to abdominal organs and/or perforations (an opening or hole into the stomach or intestine
- need to convert to an open procedure
- bleeding, pulmonary embolism, respiratory failure
- gastric outlet narrowing, which may result in blockage of the stomach
- small bowel obstruction, which may result in blockage of the intestines
- leaks involving stomach or intestine possibly leading to peritonitis (serious infection which may lead to death)
- bezoar obstruction (food particles causing blockage of the stomach)
- psychological changes and depression
- Some possible late complications after surgery:
- gastric outlet narrowing, which may result in blockage of the stomach
- stomach pouch enlarging or swelling
- ulcer formation in stomach or intestine
- small bowel obstruction
- Vitamin and nutritional deficiency and complications related to malabsorption
- anorexia (lack or loss of appetite)
- low sugar levels in the blood
- psychological changes, including possible effects from new, smaller body image that could affect spouse, family, friend relationships
- permanent alteration of dietary and bowel habits
- some of the above complications could require the need for re-operation
- death

The use of tobacco products may increase the risk of surgical complications. I am not a smoker or have not smoked for four (4) weeks prior to my surgery.

FOR FEMALE PATIENTS:

I understand that after sleeve gastrectomy surgery, my body would be unable to support a healthy pregnancy for a period of two (2) years. Further, I realize that becoming pregnant during this period after surgery could cause serious harm to my health. I pledge that I will take the proper precautions to prevent becoming pregnant. I also pledge to seek the advice of a physician should I have any questions as to the proper precautions in prevention of pregnancy. After the initial two-year period I will seek the advice of a physician prior to stopping preventive measures and possibly becoming pregnant.

3. After the operation, I understand and agree to abide by all postoperative recommendations made by my physician and the healthcare team responsible for my care including but not limited to dietary modifications and follow up care. I also agree to keep my doctor informed of my status over the years and continue clinical follow-up regularly. I have read and understand the teaching materials given to me.
4. I have been informed that there are risks associated with any surgery or procedure. The procedure has been explained in terms that are understandable to me. The explanation includes:

DOB: 10-14-67
DOS:

- The purpose and extent of the surgery or procedure to be performed
- The risks involved in the proposed procedure; including those which, even though unlikely to occur, involve serious consequences
- The possible of likely results of the proposed procedure
- Feasible alternative procedures and methods of treatment
- The possible or likely results of such alternatives
- The results likely if I remain untreated

5. I understand that during the course of the procedure, unforeseen conditions may arise which necessitate procedures different from those contemplated. I understand that if the procedure cannot be performed laparoscopically (with small incisions in the abdomen) a laparotomy (a longer incision in the abdomen) will be necessary.

6. I understand that the procedure may require that I undergo some form of anesthesia, which may have its own risks. Prior to my procedure my doctor or a representative from the department of anesthesiology will inform me of the course of anesthesia that is recommended (if any) along with its risks, benefits, discomforts, and potential complications.

7. I consent to the administration of blood/blood components if deemed necessary. The Surgeon/Anesthesiologist has explained to me the need for, risks of and alternatives to a blood transfusion if blood or blood components are needed.

8. I have been given an opportunity to ask questions and all my questions have been answered fully and satisfactorily. I acknowledge that no guarantees or assurances of weight loss have been made to me concerning the results intended from the surgery or procedure.

9. Any organs or tissues surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with accustomed practices.

10. I consent to such photographing, videotaping, televideo, or other observation of the operation/procedure by vendors, sales representatives, students and others that may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity remains anonymous and all photographs and videotapes remain the property of Orange Regional Medical Center, Arden Hill Campus and become a permanent part of the medical record. A duplicate of the photograph may be taken at the same time and released to my physician for his/her records.

11. I certify that I have read and fully understand and consent to the above surgery(s)/procedure(s) and that all additions and/or blank spaces have been completed prior to my signing. I have crossed out any paragraphs which do not pertain to me.

Irene Rumsey — Signature of Patient/Legal Guardian/Proxy/Relative

Irene Rumsey — Print Name

Relationship, if signed by person other than patient

11/1/19 1200 — Date/Time

Witness

KATIE FRITSKY — Print Name

Interpreter (if required)

Print Name

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks and potential complications of, the proposed operation(s)/procedure(s). I have explained the options, risks, benefits, discomforts and potential complications to any planned sedation I may administer. I have offered to answer any questions, and have fully answered such questions. No guarantees or warranties have been implied regarding the outcome of this procedure. I believe that the patient/relative/legal representative fully understands what I have explained and answered and has consented to the procedure(s).

JUDD — Physician Signature:

11/1/19 1198 — Date/Time

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

Surgical Weight Loss Program Patient Contract

Patient Name: Irene Rumsey
DOB: 10-14-1967
DOS: _____

I, Irene Rumsey have chosen to participate in the surgical weight loss program at Orange Regional Medical Center located in Middletown, New York or St. Luke's Cornwall Hospital located in Newburgh, New York. Part of my responsibility post-surgery is to continue to follow-up with the members of the Surgical Weight Loss team to facilitate success with gradual and sustained weight loss to my desired weight range. I am aware that my outcomes may be used for longitudinal data studies, and that my identity will not be disclosed. Furthermore, I have a full understanding of and agree to adhere to the post-surgical life style changes required.

I will attempt to follow-up with the Bariatric surgeon's office on the dates which fall on or about 1 week, 1 month, 3 months, 6 months, 1 year, and once a year for life post-surgery. I will indicate the dates below for the first year post-op, and will make every attempt to continue to *schedule annual check-ups for life. I will contact the Bariatric office in the event I change my address, telephone number or e-mail address to make it possible for a member of the Bariatric team to be able to contact me.

Signed: Irene Rumsey

Surgery Date: 11-18-19

Scheduled Appointments with Bariatric Surgeon/Provider:

	DATE	TIME
1 week	_____	____ am/pm
1 month	_____	____ am/pm
3 months	_____	____ am/pm
6 months	_____	____ am/pm
1 year	_____	____ am/pm

*Schedule annual check-ups with Bariatric surgeon *for life* after the first year.