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FAX COVER SHEET

To: IN

From: Tamara DenDanto

Company: ORMC

To Fax Number: 3331041

Fax Reference ID: TDE5DBC3CE8B76D

Date: 11/1/2019 2:10:40 PM

# of pages [incl. cover]: 4

Notes/Comments:

From Fax Number:

Sender Mailing Address: 155 Crystal Run Road

Middletown, NY 10941

NOV 8

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: Al Greenberg	DOB 12/3/41 SEX: M	Diagnosis: Nasal Stricture
ADDRESS: 23 Post Rd	Surgeon: [illegible]	Assistant: NP
Swan Lake NY 12783	CPT CODE	ICD 10 CODE J99.114 PRE-CERT #:
HOME NUMBER 845 250 4142 CELL NUMBER	INSURANCE CO. Health	INSURANCE ID NUMBER 473184735 D
PROCEDURE DATE 11/8 PROCEDURE LENGTH	☐ LEFT ☐ RIGHT ☐ BILATERAL	☐TRIAL PRODUCT
PROCEDURE ORDER FOR CONSENT: Rhinoplasty		

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 Schwalb

☐ 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. YES Anesthesia Consultation Requested ☐ Yes ☐ No

PRE-SURGICAL TESTING ORDERS ☐OTHER PCP

☐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 NKDA

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] TIME: 4:50 pm DATE: 10/31/19

STAFF SIGNATURE/PRINTED NAME: [signature] TIME: 5 pm DATE: 10.31.19

ORANGE REGIONAL MEDICAL CENTER

Consent for Surgical/Invasive Procedures and Sedation

Pt. Label

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

_____

_____

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.

(Date)	(Time)	(Patient/Health Care Agent/Surrogate/Guardian Signature)	(Printed Name)	(Relationship to Patient)
__/__/____	____ AM/PM			
__/__/____	____ AM/PM			

(Witness Signature) (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.

10/31/19 4:45 AM/PM

(Date) (Time) (Signature of Physician/Appropriately Credential Practitioner Providing Explanation) (Printed Name)

ORANGE REGIONAL MEDICAL CENTER

Consentimiento para Procedimientos Quirúrgicos o Invasivos y para Sedación

Pt. Label

Por la presente doy mi consentimiento y autorizo al Dr. _____ y a quienes él/ella designe como colaboradores o asistentes, a practicar en mi persona o en el paciente nombrado las siguientes operaciones o procedimientos: _____

_____

_____

El (nombre del médico) _____ me ha explicado y ha conversado conmigo sobre la naturaleza, propósito deseado, beneficios, riesgos significativos previsibles, complicaciones y consecuencias de dicha operación/procedimiento, como también las alternativas en caso de no practicarse la mencionada operación/procedimiento.

Doy permiso con total conocimiento y comprensión del mismo. Comprendo que la medicina no es una ciencia exacta y que existe la posibilidad de que la operación/procedimiento no produzca los beneficios o resultados deseados. Soy consciente asimismo que siempre hay riesgos y peligros para la vida o la salud asociados de manera general con la cirugía, el uso de medicamentos, procedimientos médicos y tratamientos que pueden causar consecuencias adversas normalmente no previstas con antelación pero de todos modos doy mi permiso con total consentimiento.

Se me ha explicado y comprendo que durante el transcurso de la operación/procedimiento se pueden manifestar o hallar condiciones imprevistas que requieran procedimientos quirúrgicos u otros diferentes o además de, aquellos considerados. Por lo tanto solicito y autorizo al médico anteriormente mencionado o a las personas designadas por él/ella para que realice dichas cirugías o procedimientos según se consideren necesarios o deseables.

- Comprendo que el procedimiento puede requerir que deba someterme a alguna forma de sedación, lo cual puede tener sus propios riesgos. Antes de mi procedimiento el médico me informará sobre el tipo de sedación recomendado (de haberlo) conjuntamente con sus riesgos, beneficios, molestias y potenciales complicaciones.
- Doy mi consentimiento para fotografiar, tomar video, televisar o de otra manera observar la operación/procedimiento/tratamiento según sea de utilidad para el avance del conocimiento médico o para la educación, teniendo entendido que mi identidad, o la del paciente, se mantendrá anónima y que toda fotografía o video seguirá siendo de propiedad de ORMC y/o del médico responsable.
- Doy mi consentimiento para que durante el procedimiento/operación puedan estar presentes proveedores, vendedores o estudiantes.
- Doy mi consentimiento para la administración de sangre o componentes de sangre de ser necesario. El cirujano o anestesista me ha explicado la necesidad, riesgos y alternativas de una transfusión de sangre si hubiera necesidad de sangre o componentes de sangre.

Al firmar al pie confirmo que comprendo completamente la información que se me provee, que mis preguntas han sido contestadas y doy mi consentimiento para el/los procedimiento/s anteriormente especificados.

Además doy permiso para el uso de los tejidos u órganos que fuera necesario extraer durante el procedimiento con propósitos de diagnostico patológico y posteriormente para el avance de las ciencias médicas o para educación, y para su desecho en este hospital o en alguna otra institución acorde lo determine este hospital.

(Fecha)	(Hora)	(Firma del Paciente/ Representante de Atención Médica/Sustituto/Tutor)	(Nombre en Imprenta)	(Relación con el Paciente)
__/__/____	_____ AM / PM	_____	_____	_____

(Fecha)	(Hora)	(Firma del Testigo)	(Nombre en Imprenta)
__/__/____	_____ AM / PM	_____	_____

☐ Marque aquí si el consentimiento es telefónico ☐ Marque aquí si involucró un intérprete _____ (Intérprete ID #)

He conversado sobre la naturaleza y el propósito y los riesgos y beneficios significativos previsibles del procedimiento, las alternativas, incluyendo no realizar el procedimiento, como también los riesgos y beneficios de las alternativas, y estoy satisfecho/a que el paciente o el representante legal del paciente que firmó anteriormente los comprende.

(Fecha)	(Hora)	(Firma del Médico/Profesional adecuadamente acreditado para brindar la explicación)	(Nombre en Imprenta)
__/__/____	_____ PM	_____	_____