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FAX COVER SHEET

To: ORMC BATCH

From: Cathy Guardino

Company:

To Fax Number: 333-1041

Fax Reference ID: CGU5E4D278E94E5

Date: 2/19/2020 12:18:16 PM

of pages [incl. cover]: 3

Notes/Comments:

Shahid Din surgery 2/254 dr karpoff

From Fax Number:

Sender Mailing Address: 155 Crystal Run Road

Middletown, NY 10941

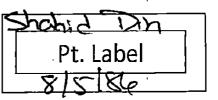
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ORANGE ME REGIONAL MEDICAL CENTER SURGICAL BOOKING AND PERIOPERATIVE ORDERS SHEET	Completed form must be faxed to the ORMC Scheduling Office Inbound 845-333-1041	Patient Label			
ANDRESS APPE	Safgeon:	Diagnosis: MadS of Safe TS Suc Assistant:			
Middle two LY 10940 HOME NUMBER PUR 282-81009	CPT CODE 23671 DISPRESSIVE CO.	INSURANCE ID NUMBER			
PROCEDURE DATE 205 DPROCEDURE LENGTH PROCEDURE ORDER FOR CONSENT:	LEFT RIGHTODE	SILATERAL OTRIAL PRODUCT			
IS PATIENT BRING SCHEDULED FOR BLOODLESS SURGERY YES NO PATIENT IS ERAS YES NO TYPE OF ADMISSION: YORMC POB OBS A SDS 23hr. INPATIENT ENDO PATIENT SPECIFIC NEEDS: FACILITY/GROUP HOME OFORENSIC PATIENT LANGUAGE LINE SPECIAL NEEDS / should not be first case PATIENT OR FAMILY MEMBER HAS HISTORY OF MALIGNANT HYPERTHERMIA OYES NO ANESTHESIA COMPLICATIONS / DIFFICULT INTUBATION YES NO PACEMAKER AICD VENDOR SPECIAL EQUIPMENT					
□ Cell Saver □ C-Arm □ Oxygen □ IMPLANT / EQUIPMENT FORM PRE-SURGICAL TESTING APPOINTMENT May we leave a message? □ □ PST MEPS being done at □ ORMC □ CRHC □ MEPS Consultation □ PST Nurse only – patient NOT on insulin or anticoagulant □ PST Phone Assessment only – (does not stratify – NOT on insulin or antico	Yes No PRIMARY DOCTOR	Diagnosis			
DIABETIC Yes No ON INSULIN Yes NO ON ANTICOAGULANT Yes No Type HISTORY SLEEP APNEA Yes No PRE-SURGICAL MEDICAL EVACUATION Surgical Risk: Minimal Vi Low Intermediate or High Health Risk: A Y B C D Medical /Cardiac Consultation by Dr Anesthesia Consultation Requested Yes No					
PRE-SURGICAL TESTING ORDERS OTHER CLASS TO THE CONTROL OF THE CONT					
PERI-OPERATIVE ORDERS FOR ERAS PATIENTS Office ERAS protocolor of Blood Glucose Monitoring Test Upon Arrival to Pre-Op Unine Pregnature At 100ml/hr NS at 100ml/hr LR at KVO Other IV fluid KUB X-Ray upon arrival to Pre-Op Intraop Venodyne Intraop Fold ALLERGIES None Known LATEX METAL OTHER	ol FOR PATIENTS WITH DIABETES ancy Test Upon Arrival to Pre-Op age	G ☑follow Perioperative Insulin Protocol Order Set e 12-55 unless H/O TAH or BTL k with NS flush			
MEDICATIONS PREOPERATIVELY FOR EBAS Patient For TOTAL JOINT Patients follow Total Joint Protocol Vancomycinmg V Gentamicinmg V Gentamicin	9	· •			
PHYSICIAN SIGNATURE /PRINTED NAME: STAFF SIGNATURE/PRINTED NAME: USAFF SIGNATURE/PRINTED NAME: Orders/Surgical Scheduling/Department of States	1 Mars xt 1	3486 018			



Consent for Surgical/Invasive Procedures and Sedation



I hereby give my consent and a	uthorize: Dr.	- P20	and those who he/she	may designate as
esseciates or assistants to perfo	rm upon me or the named	patient the followin	g operation/procedures:	<u> </u>
Kremora	24 Sod	4 13	The M	266
Left	Shoul	Der	V	
The nature, intended purpose, l	enefits, significant forese	eable risks, complic	ations and consequences of	such
operation/procedure, as well as	the alternatives if the abo	ve operation/proced	yre is/not performed, have I	peen explained and
discussed with me by (Name or	f Physician)	11 PANY	4	

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

such other institution as this Hospital may designate. uardian Signature) (Witness Signature Mark this box if interpreter was involved. Mark this box if telephone consent Interpreter ID# I have discussed the nature and purpose and the reasonably forescent risks and benefits of the procedure, the alternatives,

including not performing the procedure, as well as the risks and perfeits of the alternatives; and I am satisfied that the patient or

the patient's legal representative who signed above understands them.

al Practitioner Providing Explanation (Signature of Physician/Appropriately Cr

