

Fax

To:

Fax: 8453331041

From: Guadalupe Aguilar

Fax: (845)381-5899

Voice: (845)220-2024

Date: March 05, 2020

Company: Cornerstone Family Healthcare

Guadalupe Aguilar
Lead Referrals Specialist
21 Orchard Street
Middletown, NY10940
Tel: (845)220-2024
Fax: (845)381-5899

-----Original Message-----

From: Guadalupe Aguilar

Sent: Thursday, March 05, 2020 12:26 PM

To: '8457414835@fax.cornerstonefh.org' <8457414835@fax.cornerstonefh.org>

Subject:


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Guadalupe Aguilar
Lead Referrals Specialist
21 Orchard Street
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 ORANGE REGIONAL MEDICAL CENTER SURGICAL BOOKING AND PERIOPERATIVE ORDERS SHEET		Completed form must be faxed to the ORMC Scheduling Office Inbound 845-333-1841		Scheels, Corinne A ID: 195042 DOB: 08-12-1992 Today's Date: 02-20-2020	
PATIENT NAME: Scheels, Corinne		DOB: 8/12/92	SEX:	Diagnosis: Endometrial polyp	
ADDRESS: 31 Maidstone Drive		Surgeon: JOUVO		Assistant:	
Walden NY 12586		CPT CODE: 58558		ICD 10 CODE: N84.0	PRE-CERT #:
HOME NUMBER: (845) 568-7353	CELL NUMBER:	INSURANCE CO.: Fidelis		INSURANCE ID NUMBER: 74312202100	
PROCEDURE DATE: 3/31 PROCEDURE LENGTH:		<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BILATERAL <input type="checkbox"/> TRIAL PRODUCT			
PROCEDURE ORDER FOR CONSENT: Operative hysteroscopy Dilation & Curettage - True clear					

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: **TRUE clear**

☐ 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. _____ Anesthesia Consultation Requested ☐ Yes ☐ No

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 Order Set

☐ Blood Glucose Monitoring Test Upon Arrival to Pre-Op ☒ Urine Pregnancy Test Upon Arrival to Pre-Op age 12-65 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 **NONE** 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: **Jouvo** TIME: **1PM** DATE: **2/20/2020**

STAFF SIGNATURE / PRINTED NAME: _____ TIME: _____ DATE: _____

