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

FAX COVER SHEET

To: IN

From: Petak, Tamara

Company: ORMC

To Fax Number: 3331041

Fax Reference ID: TDE5E442B1DA8DC

Date: 2/12/2020 4:43:06 PM

# of pages [incl. cover]: 2

Notes/Comments:

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:
Salvatore Rappa	7/10/52	M	Peripheral Vascular Disease
ADDRESS:	**Surgeon:**		**Assistant:**
46 Summitville Road	Fiorenti		
Wurtsboro, NY 12790	**CPT CODE** 36246	**ICD 10 CODE** I70213	**PRE-CERT #:**
HOME NUMBER 5137 (845) 644-5137	**CELL NUMBER**	**INSURANCE CO.** Medicare Part B	**INSURANCE ID NUMBER** 1VD9NG1CX38

PROCEDURE DATE 3/9/2020 PROCEDURE LENGTH _____ ☐ LEFT ☒ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT:

Right lower Extremity angiogram with possible balloon angioplasty and stenting

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

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

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 Glaswell

☒ PST MEPS being done at ☐ ORMC ☒ CRHC ☐ MEPS Consultation by Dr. _____ Diagnosis _____

☐ PST Nurse only – patient NOT on insulin or anticoagulant 2.27

☒ 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. JAFRI 2.27 Anesthesia Consultation Requested ☐ Yes ☐ No

*on ASA

MEPS and cardiac

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 12-55 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 Penicillins

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: _____ TIME: 11:30 AM DATE: 2/11/2020

STAFF SIGNATURE/PRINTED NAME: _____ TIME: 11:30 DATE: 2-11-20

EXT 46711