

Fax

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Date: January 24, 2020
Company: Cornerstone Family Healthcare

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Sent: Friday, January 24, 2020 4:42 PM
To: Guadalupe Aguilar <gAguilar@cornerstonefh.org>
Subject:

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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 845-333-1041		Salisbury, Christina ID: 188351 DOB: 11-14-1981 Today's Date: 01-24-2020	
PATIENT NAME: Christina Salisbury		DOB:	SEX: F	Diagnosis: Elective Sterilization	
ADDRESS: 208 Lakewood drive Milford, PA 18337		Surgeon: Dr. Janza		Assistant: Dr. Jouve	
HOME NUMBER:		CELL NUMBER: 570-217-7569		CPT CODE: 58661	ICD 10 CODE: Z30.21 Z64.1
INSURANCE CO.: Tricare		INSURANCE ID NUMBER: 379889971		PRE-CERT #:	
PROCEDURE DATE: 2/18/2020		PROCEDURE LENGTH: 1 ⁰		<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input checked="" type="checkbox"/> BILATERAL <input type="checkbox"/> TRIAL PRODUCT	
PROCEDURE ORDER FOR CONSENT: Laparoscopic bilateral salpingectomy - TAPS Block possible laparotomy.					

 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 _____

☐ 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 2 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 _____

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: Janza TIME: 11:56pm DATE: 1/22/2020

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

