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

FAX COVER SHEET

To: ormc

From: Donna Brundage

Company:

To Fax Number: 3331041

Fax Reference ID: DBR5E384F908FC2

Date: 2/3/2020 4:51:22 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: Andrea Abruzzese	DOB: 8/31/66 SEX: F	Diagnosis: Vaginal prolapse
ADDRESS: 58 Horan Rd	Surgeon:	Assistant:
Slate Hill NY 10973	CPT CODE 57240 57260 57282 57288	ICD 10 CODE N81.10 PRE-CERT #:
HOME NUMBER 8453556803 CELL NUMBER	INSURANCE CO. GHI PPO	INSURANCE ID NUMBER

PROCEDURE DATE 4/10/20 PROCEDURE LENGTH ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT: [illegible handwriting] vaginal prolapse, cystoscopy

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______ ☒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 Morphine

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 risl

☐ Vancomycin ______mg IV ☑Gentamicin 80 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: 4p DATE: 2/3/20

STAFF SIGNATURE/PRINTED NAME: [signature] TIME: 4:4?p DATE: 2/3/20