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FAX COVER SHEET

To: ORMC BATCH

From: Guardino, Cathy

Company:

To Fax Number: 333-1041

Fax Reference ID: CGU5E3ACF9E9FAD

Date: 2/5/2020 2:22:06 PM

# of pages [incl. cover]: 4

Notes/Comments:

Lorianna Nizolek surgery 3/10 dr Malhotra

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: Lorianne Nizolek	DOB: 8/4/74	SEX: F	Diagnosis: gallstones
ADDRESS: 172 Collabar Rd	Surgeon: Malhotra		Assistant:
Montgomery NY 12549	CPT CODE: 47562		ICD 10 CODE: K80.10 / PRE-CERT #:
HOME NUMBER / CELL NUMBER: 283-7266	INSURANCE CO.: Aetna		INSURANCE ID NUMBER: W207192103

PROCEDURE DATE 3/10 PROCEDURE LENGTH ______ ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT:
robotic assisted cholecystectomy - possible open

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 Bartamel 2/17 11:15

☒ PST MEPS being done at ☐ ORMC ☒ CRHC ☐ MEPS Consultation by Dr. Bartamel 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. & Pulmonary Dr. Grundquist 2/24/20 5:15 Anesthesia Consultation Requested ☐ Yes ☐ No

PRE-SURGICAL TESTING ORDERS ☐ OTHER CRHC 2/13 CRHC 2/13

☐ 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 12-25 unless H/O TAH or STL

☒ 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) ~~2~~ gm IV ☐ Surgeon reviewed PCN allergy – benefit outweighs risk

☐ Vancomycin ______ mg IV ☐ Gentamicin ______ mg IV ☒ Clindamycin 900 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: J. Malhotra TIME: 11:30 AM DATE: 2/5/2020

STAFF SIGNATURE/PRINTED NAME: Cathy Sudol TIME: 11:30 AM DATE: 2/5/20

94972

Ext 13160