



155 Crystal Run Road
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FAX COVER SHEET

To: ORMC

From: Laura Doty

Company:

To Fax Number: 845-333-1041

Fax Reference ID: LAD5E2AF31748B1

Date: 1/24/2020 1:37:22 PM

of pages [incl. cover]: 2


Notes/Comments:

From Fax Number:

Sender Mailing Address: 155 Crystal Run Road
Middletown, NY 10941

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Antibiotics Updated

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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 | | Patient Label | |
| PATIENT NAME: <u>Amanda Tentas</u> | | DOB: <u>5-23-93</u> | SEX: <u>F</u> | Diagnosis: <u>Previous Cesarean Section</u> | |
| ADDRESS: <u>P.O. Box 341</u> | | Surgeon: <u>Lezade Kipolione, MD</u> | | Assistant: <u>Chari Cruz, MD</u> | |
| <u>Spring Glen, N.Y. 12483</u> | | CPT CODE: <u>59510 58700</u> | ICD 10 CODE: <u>034.21, 230.2</u> | PRE-CERT #: | |
| HOME NUMBER: <u>845-210-4041</u> | CELL NUMBER: <u>845-321-1477</u> | INSURANCE CO.: <u>Empire Plan</u> | INSURANCE ID NUMBER: <u>890769056</u> | | |
| PROCEDURE DATE: <u>1-27-20</u> | | PROCEDURE LENGTH: | <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BILATERAL | <input type="checkbox"/> TRIAL PRODUCT | |
| PROCEDURE ORDER FOR CONSENT: | | | | | |
| <u>Repeat Cesarean Section and Bilateral Salpingectomy</u> | | | | | |

IS PATIENT BEING SCHEDULED FOR BLOODLESS SURGERY ☐ YES ☐ NOPATIENT IS ERAS ☐ YES ☐ NOTYPE OF ADMISSION: ☒ ORMC ☐ POB ☐ OBS ☐ SDS ☐ 23hr. ☒ INPATIENT ☐ ENDOPATIENT SPECIFIC NEEDS: ☐ FACILITY/GROUP HOME ☐ FORENSIC PATIENT ☐ LANGUAGE LINE ☐ SPECIAL NEEDS / should not be first casePATIENT OR FAMILY MEMBER HAS HISTORY OF MALIGNANT HYPERTHERMIA ☐ YES ☐ NOANESTHESIA 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 ☒ NoPRE-SURGICAL TESTING ORDERS ☒ OTHER RPR, BUN, Creatinine☒ T & S # OF UNITS ☒ CBC ☐ BMP/CMP ☐ PT INR ☐ PTT ☐ MSSA/MRSA screen culture ☒ UA ☐ 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 indicatedPERI-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: Lezade Kipolione, MD TIME: 8:56am DATE: 12-26-19STAFF SIGNATURE /PRINTED NAME: Chari Cruz, MD TIME: 8:50am DATE: 12-26-19