



155 Crystal Run Road  
Middletown, NY 10941

845•703•6999  
[www.crystalrunhealthcare.com](http://www.crystalrunhealthcare.com)

## FAX COVER SHEET

To: ORMC BATCH

From: Cathy Guardino

Company:

To Fax Number: 333-1041

Fax Reference ID: CGU5E501128BAD5

Date: 2/21/2020 5:19:28 PM

# of pages [incl. cover]: 3


Notes/Comments:

Anarosa Soto surgery 4/24 dr sacks

From Fax Number:

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

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 <b>ORANGE REGIONAL MEDICAL CENTER</b> 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>Anarosa Soto</u>		DOB: <u>9/28/1987</u>	SEX: <u>F</u>	Diagnosis: Symptomatic Abdominal Pannus	
ADDRESS: <u>143 Center Street</u>		Surgeon: <u>Sacks</u>		Assistant: <u>Andrea Gerspach</u>	
<u>Ellenville, NY 12428</u>		CPT CODE 15830, 15847	ICD 10 CODE E65	PRE-CERT #:	
HOME NUMBER <u>(845) 706-2979</u>	CELL NUMBER	INSURANCE CO. <u>Fidelis</u>	INSURANCE ID NUMBER <u>7439467200</u>		
PROCEDURE DATE <u>4/24/2020</u>		PROCEDURE LENGTH <u>4-4.5</u>		<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BILATERAL <input type="checkbox"/> TRIAL PRODUCT	
PROCEDURE ORDER FOR CONSENT:					
Panniculectomy with umbilical transposition & facial plication					

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. CRHC - should not have Anesthesia Consultation Requested ☐ Yes ☒ NoPRE-SURGICAL TESTING ORDERS ☐ OTHER \_\_\_\_\_☐ T & S # OF UNITS 1 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: Sacks TIME: 12:29 DATE: 2/19/2020STAFF SIGNATURE/PRINTED NAME: Cathy Ananda TIME: 12:29 DATE: 2/19/2020

610588

EXT 13488





# Consent for Surgical/Invasive Procedures and Sedation

Pt. Label

I hereby give my consent and authorize: Dr. Sacks and those who he/she may designate as associates or assistants to perform upon me or the named patient the following operation/procedures: \_\_\_\_\_

Panniculectomy with Umbilical transposition & fascial plication

The nature, intended purpose, benefits, significant foreseeable risks, complications and consequences of such operation/procedure, as well as the alternatives if the above operation/procedure is not performed, have been explained and discussed with me by (Name of Physician) Sacks

I give permission with full knowledge and understanding thereof. I understand that medicine is not an exact science and that there is the possibility that the operation/procedure may not have the benefits or results intended. I am also aware that there are always risks and dangers to life and health associated generally with surgery, use of medication, medical procedures and treatments which can cause adverse consequences not ordinarily anticipated in advance, but I give this permission with full assent nevertheless.

It has been explained to me and I understand that during the course of the operation/procedure, unforeseen conditions may be revealed or encountered which necessitate surgical or other procedures in addition to or different from those contemplated. I therefore request and authorize the above named physician or his/her designees to perform such additional surgical or other procedures as are deemed necessary or desirable.

- I understand that the procedure may require that I undergo some form of sedation, which may have its own risks. Prior to my procedure my doctor will inform me of the course of sedation that is recommended (if any) along with its risks, benefits, discomforts, and potential complications.
- I consent to photographing, videotaping, televising or other observation of the operation/procedure/treatment as may be purposeful for the advance of medical knowledge and or education, with the understanding that my/the patient's identity remain anonymous and all photographs and videotapes remain the property of ORMC and/or the responsible physician.
- I consent to the presence of Vendors/Salespersons/Students during the procedure/operation.
- I consent to the administration of blood/blood components if deemed necessary. The Surgeon has explained to me the need for, risks of and alternatives to a blood transfusion if blood or blood components are needed.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the procedure(s) specified above.

I further grant permission for the use of such tissues and/or organs as it may be necessary to remove during the procedure, for purposes of pathological diagnosis and thereafter for the advancement of medical science and education, and their disposal, at this Hospital or at such other institution as this Hospital may designate.

2/19/2020 12:32 PM [Signature] Aransa Soto -self  
(Date) (Time) (Patient/Health Care Agent/Surrogate/Guardian Signature) (Printed Name) (Relationship to Patient)

2/19/2020 12:32 PM [Signature] Jahaira Roman Esob Roman  
(Date) (Time) (Witness Signature) (Printed Name)

☐ Mark this box if telephone consent

☐ Mark this box if interpreter was involved.

Interpreter ID # \_\_\_\_\_

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the procedure, the alternatives, including not performing the procedure, as well as the risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

2/19/2020 12:29 PM [Signature]  
(Date) (Time) (Signature of Physician/Appropriately Credentialed Practitioner Providing Explanation)

Dr. Sacks  
(Printed Name)

