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: Paul,Fania

DOB: 11-4-87 SEX: F

Diagnosis:

ADDRESS: 93 Berkman Drive

Middletown, NY 10941

Surgeon: Stefan G. Chevalier, D.O.

Assistant:

CPT CODE

ICD 10 CODE

PRE-CERT #:

HOME NUMBER

CELL NUMBER 845-380-2750 ~~546-765-0629~~

INSURANCE CO. cosmetic/self pay

INSURANCE ID NUMBER

PROCEDURE DATE 2-18-20 PROCEDURE LENGTH 4hrs. ☐ LEFT ☐ RIGHT ☒ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT:

Removal of bilateral breast implants and bilateral breast lift ($1,750)

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 Percocet

ALLERGIC REACTION itchy

MEDICATIONS PREOPERATIVELY FOR ERAS Patients ☑ follow ERAS medication order protocol

☑ FOR TOTAL JOINT Patients follow Total Joint Protocol ☐ Cefazolin (Ancef) _____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: _____ Stefan G. Chevalier, D.O. TIME: 10:15 DATE: 1.31.2020

STAFF SIGNATURE/PRINTED NAME: _____ Sarah Burke TIME: 10:15 DATE: 1.31.2020

FAX 1.31.20