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Middletown, NY 10941

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FAX COVER SHEET

To: ORMC

From: Noreen Maloney

Company:

To Fax Number: 3331041

Fax Reference ID: NMA5E4EB97ED08E

Date: 2/20/2020 4:53:14 PM

of pages [incl. cover]: 2

Notes/Comments:


DOS 03/2/2020

Dr. Fioranti

From Fax Number:

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

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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>Joseph O'Brien</u>		DOB: <u>6/27/58</u>	SEX: <u>M</u>	Diagnosis: <u>Peripheral Vascular Disease</u>	
ADDRESS: <u>36 Edinburgh Rd.</u>		Surgeon: <u>Fioranti</u>		Assistant:	
<u>Middletown, NY 10941</u>		CPT CODE: <u>35666</u>	ICD 10 CODE: <u>I73.9</u>	PRE-CERT #:	
HOME NUMBER: <u>(845) 494 0922</u>	CELL NUMBER: <u>845 494 0786*</u>	INSURANCE CO.: <u>AFFINITY</u>	INSURANCE ID NUMBER: <u>171003380</u>		
PROCEDURE DATE: <u>3/2/20</u> PROCEDURE LENGTH: _____		<input checked="" type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BILATERAL <input type="checkbox"/> TRIAL PRODUCT			
PROCEDURE ORDER FOR CONSENT: <u>Left femoral to anterior tibial artery bypass</u>					

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: DR. LIBY MATTHEW

☒ PST MEPS being done at ☐ ORMC ☒ CRHC ☐ MEPS Consultation by Dr. Liby Matthew 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 *ON ASA + PLAVIX - continue

Surgical Risk: ☐ Minimal ☐ Low ☒ Intermediate or High Health Risk: ☐ A ☐ B ☒ C ☐ D

☐ Medical /Cardiac Consultation by Dr. Winchester Penny Anesthesia Consultation Requested ☐ Yes ☐ No

PRE-SURGICAL TESTING ORDERS ☐ OTHER _____

☒ T & S # OF UNITS 4 ☒ 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 Clindamycin, Morphine, Penicillins

ALLERGIC REACTION _____

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: _____ TIME: 3:00 PM DATE: 2/20/2020

STAFF SIGNATURE/PRINTED NAME: N. Maloney TIME: 3:00 PM DATE: 2/20/2020

703-6477



Orders/Surgical Scheduling/Department of Surgery and Medicine/December, 2018

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