Crystal Run Healthcare
155 Crystal Run Road
Middletown, NY 10941
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FAX COVER SHEET

To: ORMC BATCH

From: Cathy Guardino

Company:

To Fax Number: 333-1041

Fax Reference ID: CGU5E84C387D2C2

Date: 4/1/2020 4:38:26 PM

# of pages [incl. cover]: 4

Notes/Comments:

Tracy Ritchie surgery 4/10 Dr KArpoff

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:	DOB:	SEX:	Diagnosis:
Tracy Ritchie	8/26/63	F	510 Abnormal mammo
ADDRESS: 22 Orchard St	Surgeon: KARPOFF		Assistant: SCHEURER, NP
Warwick, NY 10990	CPT CODE 19125		ICD 10 CODE R92.8 / PRE-CERT #:
HOME NUMBER ~~845~~	CELL NUMBER 201-370-2378	INSURANCE CO. BCBS	INSURANCE ID NUMBER KQM3H2N99475

PROCEDURE DATE 4/10 PROCEDURE LENGTH 30 MINS ☒ LEFT ☐ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT:

Left BREAST NEEDLE LOCALIZATION AND EXCISION

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 4/3 1045 CRHC 4/3 1000

☐ 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 _____

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: H.KARPOFF/ TIME: 380 DATE: 4/1/20

STAFF SIGNATURE/PRINTED NAME: _____ TIME: 38 DATE: 4/1/20

2/13 23144

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

EXT 13488

ORANGE REGIONAL MEDICAL CENTER 4/10

PROCEDURAL INTERVENTIONAL RADIOLOGY
Consult/Order Form

IR Scheduling Office
Phone: 845-333-7900 opt 1
Fax: 845-333-9009

Patient Information

Name: Ritchie, Tracy (Last, First, MI) DOB: 8/26/63 Gender: ☐ Male ☒ Female

Phone: Preferred# 201-370-2378 Alternate #

Email Address: Preferred language:

Insurance Company: BCBS Pre-Certification Number:

Home Care Referral: ☐ Yes ☒ No If yes, name of agency: mammo

Procedure requested: Needle Localization Left breast ☒ Left ☐ Right ☐ Bilateral

Diagnosis/Indication: Abnormal mammo

Isolation Precautions:

☆ Needed Prior to making appointment ☐ IR Form ☐ Labs (within 30 days) ☐ Films Sent (Mailed or through VPN) ☆

Invasive Procedure – Physician Orders History and Physical

Present Illness: Date: 4/1/20

Allergies NKA

Medications/Dosage

Anticoagulants Ø

Past Surgery

Past Medical History

Physical Exam: Height Weight Temp Pulse R BP /

	Normal	Abnormal	Describe Abnormal Findings Below
HEENT			
Breast			
Cardiovascular			
Heart/Lungs			
Abdomen			
Genitalia			
Musculoskeletal			
Neurologic			
Psychosocial			
Plan			

Required Information (please print clearly)

Form Completed by: Kimberly Rose Signature: KimberlyRose

Office Phone (845) 703-6999 Office Fax (845) 703-6234

Physician Name: H. KARPOFF, MD Physician Signature:

Time: 330 Date: 4/1/20

THIS SECTION TO BE COMPLETED BY ORMC CLINICAL QUEUE NURSE

Minimal Procedure Risk: M1 M2 M3 M4 M5 Consults needed ☐ PST ☐ Hospitalist ☐ Other:

RN Signature/Printed Name: Date: / / Time:

THIS SECTION TO BE COMPLETED BY ORMC SCHEDULING: PST Date: / / Time:

Pt. Label

ORANGE REGIONAL MEDICAL CENTER

Consent for Surgical/Invasive Procedures and Sedation

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

Left ; **BREAST NEEDLE LOCALIZATION AND EXCISION**

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) DR. KARPOFF.

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 forms 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 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.

4/1/20 3:30 AM/PM (Date) (Time) Tracy Ritchie (Patient/Health Care Agent/Surrogate/Guardian Signature) Tracy Ritchie (Printed Name) Self (Relationship to patient)

4/1/20 3:30 AM/PM (Date) (Time) Kim A Rose (Witness Signature) Kimberly Rose (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 patient's legal representative who signed above understands them.

4/1/20 3:30 AM/PM (Date) (Time) _____ (Signature of Physician/Appropriately Credential Practitioner Providing Explanation) H. KARPOFF, MD (Printed Name)