Fax

To:
Fax: 8453331041

From: Guadalupe Aguilar
Fax: (845)381-5899
Voice: (845)220-2024

Date: March 05, 2020
Company: Cornerstone Family Healthcare

Guadalupe Aguilar
Lead Referrals Specialist
21 Orchard Street
Middletown, NY10940
Tel: (845)220-2024
Fax: (845)381-5899

-----Original Message-----
From: Guadalupe Aguilar
Sent: Thursday, March 05, 2020 12:26 PM
To: '8457414835@fax.cornerstonefh.org' <8457414835@fax.cornerstonefh.org>
Subject:

_____
E-mail automatically created by the free PDFCreator www.pdfforge.org

Guadalupe Aguilar
Lead Referrals Specialist
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Middletown, NY10940
Tel: (845)220-2024
Fax: (845)381-5899

8455651364

ORANGE REGIONAL MEDICAL CENTER
SURGICAL BOOKING AND PERIOPERATIVE ORDERS SHEET

Completed form must be faxed to the ORMC Scheduling Office Inbound 845-333-1841

Scheels, Corinne A
ID: 195042 DOB: 08-12-1992
Today's Date: 02-20-2020

PATIENT NAME: Scheels, Corinne
DOB: 8/12/92 SEX:
Diagnosis: Endometrial polyp
ADDRESS: 31 Maidstone Drive
Surgeon: Jouvo
Assistant:
Walden NY 12586
CPT CODE 58558
ICD 10 CODE N84.0
PRE-CERT #:
HOME NUMBER (845)778-7353
CELL NUMBER
INSURANCE CO. Fidelis
INSURANCE ID NUMBER 743122021 00
PROCEDURE DATE 3/31 PROCEDURE LENGTH ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT
PROCEDURE ORDER FOR CONSENT:
Operative hysteroscopy Dilation & Curettage - Tru Clear

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 Tru clear

☐ 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 _____

ALLERGIC REACTION NKDA

MEDICATIONS PREOPERATIVELY None 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: 1PM DATE: 2/20/2020

STAFF SIGNATURE/PRINTED NAME: _____ TIME: _____ DATE: _____