Fax

To:
Fax: 8453331041

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

Date: January 24, 2020
Company: Cornerstone Family Healthcare

Guadalupe Aguilar
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From: ORCHARD-2FL-COPIER@cornerstonefh.org
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Sent: Friday, January 24, 2020 4:42 PM
To: Guadalupe Aguilar <gAguilar@cornerstonefh.org>
Subject:

rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If you have received this transmission in error please notify us immediately, either by contacting the sender at the electronic mail address noted above, calling the Cornerstone Corporate Compliance Department at (845)522-5736 or sending an email to mcalero@cornerstonefh.org . Please delete this email and destroy all copies/attachments of this message. Thank you.

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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

Salisbury, Christina
ID: 186351 DOB: 11-14-1981
Today's Date: 01-24-2020

PATIENT NAME: Christina Salisbury	DOB:	SEX: F	Diagnosis: Elective Sterilization
ADDRESS: 208 Lakewood drive	Surgeon: Dr. Tanza		Assistant: Dr. Jouve.
Milford, PA, 18337.	CPT CODE 58661		ICD 10 CODE Z30.2 | Z64.1 PRE-CERT #:
HOME NUMBER	CELL NUMBER (570)217-7569	INSURANCE CO. Tricare	INSURANCE ID NUMBER 379888971

PROCEDURE DATE 2/18/2020 PROCEDURE LENGTH 1° ☐ LEFT ☐ RIGHT ☑ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT:

Laparoscopic bilateral salpingectomy + TAPS Block
Possible laparatomy.

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 2 ☑ 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-operativeorders _____

PHYSICIAN SIGNATURE /PRINTED NAME: _____ TIME: 11:56pm DATE: 1/22/2020

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