Crystal Run Healthcare
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FAX COVER SHEET

To: ORMC

From: Noreen Maloney

Company:

To Fax Number: 3331041

Fax Reference ID: NMA5DB829F19B9D

Date: 10/29/2019 12:00:46 PM

# of pages [incl. cover]: 2

Notes/Comments:

DOS 11/15

Dr. Uy

Updated with patient phone contact

From Fax Number:

Sender Mailing Address: 155 Crystal Run Road

Middletown, NY 10941

Revised w/phone N.M.

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: David Campagna	DOB: 7/6/1963 SEX: male	Diagnosis: Hernia
ADDRESS: 42 Ridge Street Apt. 10	Surgeon:	Assistant:
Pearl River, NY 10965	CPT CODE 49650	ICD 10 CODE K40.90 PRE-CERT #:
HOME NUMBER (914) 689-5744	CELL NUMBER (914) 689-5744	INSURANCE CO. Aetna
		INSURANCE ID NUMBER 743922547

PROCEDURE DATE NOV 15 PROCEDURE LENGTH 1hr ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT:

Robotic Assisted Right inguinal hernia repair with mesh

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 CRHC

☐ 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. PCP DR. PATEL 11/7 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 _____

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: _____ TIME: 10/29/19 DATE: 11/12

STAFF SIGNATURE/PRINTED NAME: _____ TIME: 10/29/19 DATE: _____

87749 N. Mahney PO 12/13