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: Catherine Scarna		**DOB:** 10/08/49	**SEX:** F	**Diagnosis:** malignant neoplasm ascending colon
ADDRESS: 297 Sugar Loaf Rd		**Surgeon:** J Pardo		**Assistant:**
Grahamsville NY 12740		**CPT CODE** 44205		**ICD 10 CODE** C18.2 / **PRE-CERT #:**
HOME NUMBER (845) 985-2080	**CELL NUMBER**	**INSURANCE CO.** B/CBS		**INSURANCE ID NUMBER** USP122026163001

PROCEDURE DATE 04/29/20 **PROCEDURE LENGTH** ____ ☐ **LEFT** ☐ **RIGHT** ☐ **BILATERAL** ☐ **TRIAL PRODUCT**

PROCEDURE ORDER FOR CONSENT:

Robotic laparoscopic right hemicolectomy, possible open right hemicolectomy

IS PATIENT BEING SCHEDULED FOR BLOODLESS SURGERY ☐ YES ☒ NO   PATIENT IS ERAS ☒ YES ☐ NO (Cross class)

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 Cindy G [illegible], NP

☒ 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 Aspirin **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 ☐ NSat 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) ____ 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:** 1140 **DATE:** 4/20/2020

STAFF SIGNATURE/PRINTED NAME: ____ **TIME:** 1134 **DATE:** 4/20/20

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