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: JOSEPH BULL	DOB: 11/24/15	SEX: M	Diagnosis: MEATAL STENOSIS	
ADDRESS: 108 ORRS MILLS ROAD	Surgeon: DR. ZELKOVIC		Assistant:	
SALISBURY MILLS, NY 12577	CPT CODE 53450,53605		ICD 10 CODE N35.911	PRE-CERT #:
HOME NUMBER 845-496-6856	CELL NUMBER 845-591-6469	INSURANCE CO. SEE ATTACHED	INSURANCE ID NUMBER SEE ATTACHED	
PROCEDURE DATE 12/19/19 PROCEDURE LENGTH 15MIN ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐TRIAL PRODUCT				
PROCEDURE ORDER FOR CONSENT: MEATOPLASTY, URETHRAL CALIBRATION				

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 N/A

☐ 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 N/A

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) _____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: P. Zelkovic MD TIME: 2:33 pm DATE: 11-1-19

STAFF SIGNATURE/PRINTED NAME: Beena TIME: 2:33 pm DATE: 11-1-19

Patient Information

Patient Name: Joseph Bull
Patient Address: 108 Orrs Mills Rd Salisbury Mills NY 12577
Home Phone: 845-496-6856
Work Phone: (845) 591-6469-Dcell
Date of Birth: 11/24/2015
Social Security Number:

Insurance Information

Primary Insurance:Bcbs Bluecard Local (out of state) PO Box 3877 Church Street Station, New York, NY, 10008-3877
Phone: 800-713-4173
Subscriber Name: Bull, Joseph
Subscriber ID: NEI801064013
Group Number: P13346
Date of Birth: 11/24/2015

SX

12-19-19