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Middletown, NY 10941

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FAX COVER SHEET

To: IN

From: Tamara DenDanto

Company: ORMC

To Fax Number: 3331041

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of pages [incl. cover]: 2

Notes/Comments:

From Fax Number:

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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		Patient Label	
PATIENT NAME: <u>Janet Ferrarie</u> ID-1744		DOB: <u>10-11-44</u> SEX: <u>F</u>		Diagnosis: <u>atherosclerosis claudication</u>	
ADDRESS: <u>74 Sturgis Road Apt 9</u> <u>Monticello, NY 12701</u>		Surgeon: <u>Fionanti</u>		Assistant:	
HOME NUMBER: <u>845-794-4524</u> CELL NUMBER: <u>(845) 665-4157</u>		CPT CODE: <u>10061</u>		ICD 10 CODE: <u>F70.23</u> PRE-CERT #:	
INSURANCE CO.: <u>Medicare</u>		INSURANCE ID NUMBER: <u>5T46Q82JK71</u>			
PROCEDURE DATE: <u>3/30/20</u> PROCEDURE LENGTH: <u>1.0</u>		<input checked="" type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BILATERAL <input type="checkbox"/> TRIAL PRODUCT			
PROCEDURE ORDER FOR CONSENT: <u>incision and drainage of left lower extremity</u>					

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: [Signature]

☐ PST MEPS being done at ORMC ☐ CRHC ☒ MEPS Consultation by Dr. [Signature] 3-18

☐ 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: Coumadin → hold

HISTORY SLEEP APNEA ☐ Yes ☒ No

PRE-SURGICAL MEDICAL EVALUATION

Surgical Risk: ☐ Minimal ☐ Low ☒ Intermediate or High Health Risk: ☐ A ☐ B ☒ C

☒ Medical / Cardiac Consultation by Dr. [Signature] 3-18 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 ☒ CXG ☐ 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: morphine, vancomycin

ALLERGIC REACTION: _____

MEDICATIONS PREOPERATIVELY

FOR ERAS Patients ☒ follow ERAS medication order protocol

☒ FOR TOTAL JOINT Patients follow Total Joint Protocol ☐ Cefazolin (Ancel) _____ 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: [Signature] TIME: 8:30 DATE: 3-3-20

STAFF SIGNATURE/PRINTED NAME: [Signature] TIME: 7:30 DATE: 3-3-20

