Crystal Run Healthcare
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FAX COVER SHEET

To: ormc

From: Donna Brundage

Company:

To Fax Number: 3331041

Fax Reference ID: DBR5E501397D7A6

Date: 2/21/2020 5:29:56 PM

# of pages [incl. cover]: 2

Notes/Comments:

From Fax Number:

Sender Mailing Address: 155 Crystal Run Road
Middletown, NY 10941

Rescheduled 2/24/20 (420)

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: Mauro Brune	DOB: 6/16/61 SEX: M	Diagnosis: right ureteral calculus	
ADDRESS: 81 Jarkva Drive Bloomingburg, NY 12721	Surgeon: Rowe	Assistant:	
	CPT CODE 52356	ICD 10 CODE N20.1	PRE-CERT #:
HOME NUMBER 845-361-7377	CELL NUMBER 845-394-8993	INSURANCE CO R/C BlueCard	INSURANCE ID NUMBER
PROCEDURE DATE [redacted]	PROCEDURE LENGTH 1 hr	☐ LEFT x RIGHT	☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT: cystoscopy, right retrograde pyelogram, right ureteroscopy, laser lithotripsy, right ureteral stent

RU 2/24/20

IS PATIENT BEING SCHEDULED FOR BLOODLESS SURGERY ☐ YES x NO PATIENT IS ERAS ☐ YES x NO

TYPE OF ADMISSION: x ORMC ☐ POS ☐ OBS x 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 x NO

ANESTHESIA COMPLICATIONS / DIFFICULT INTUBATION ☐ YES x NO

☐ PACEMAKER ☐ AICD VENDOR _____ SPECIAL EQUIPMENT holmium laser

☐ Cell Saver x 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 ☐ CCHC ☐ 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 ☐ High Health Risk: ☐ A ☒ B ☐ C ☐ D

☒ Medical /Cardiac Consultation by Dr. Fletcher 2/3/20 ☒ Anesthesia Consultation Requested ☐ Yes ☐ No

PRE-SURGICAL TESTING ORDERS ☐ OTHER _____ [redacted]

☐ T & B # OF UNITS _____ ☒ CBC ☒ BMP/CMP ☐ PT INR ☐ PTT ☐ MSSA/MRSA screen culture ☐ U/A ☒ EKG ☒ XRAY ☐ 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: _____ Steven Rowe, MD TIME: 1134/19 DATE: 1815

STAFF SIGNATURE/PRINTED NAME: _____ TIME: 1145/19 DATE: 12/19/19