Rescheduled to 5/20/20

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:	DOB:	SEX:	Diagnosis:
JOLANTA ZIELINSKI	05/12/1957	FEMALE	THYROID MASS
ADDRESS:	**Surgeon:**		**Assistant:**
311 NEW VERNON ROAD	SERGEY KOYFMAN		KAREN PAUL
	CPT CODE		**ICD 10 CODE** / **PRE-CERT #:**
MIDDLETOWN, NY 10940	60220		E07.9 / NONE REQUIRED
HOME NUMBER / **CELL NUMBER**	**INSURANCE CO.**		**INSURANCE ID NUMBER**
(845) 386-4909 / (914) 850-0745	UNITED HEALTHCARE		944529846

~~5/26/20~~ PROCEDURE DATE ~~04/08/2020~~ PROCEDURE LENGTH 2 HOURS 1.5h ☒ LEFT ☐ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT: HEMI-THYROID - LEFT FROZEN SECTION

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 ALVIN VIRAY

☐ 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. ALVIN VIRAY 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 ProtocolOrderSet

☐ 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 NECTAR FLAVORS

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: _____ SERGEY KOYFMAN TIME: 4:23PM DATE: 02/18/2020

STAFF SIGNATURE/PRINTED NAME: _____ DESIREE VADI TIME: 4:23PM DATE: 02/18/2020

FAXED 2/24/20