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: John Theodore	DOB: 12/15/86 SEX: M	Diagnosis: Acute superficial gastritis	
ADDRESS: 24 Wayne Court Middletown, NY 10941	Surgeon: Kazbay	Assistant: w/o hemmorhage	
	CPT CODE 43235	ICD 10 CODE K29.00	PRE-CERT #:
HOME NUMBER 718-207-2520 CELL NUMBER	INSURANCE CO. MSHIP BCBS UHC	INSURANCE ID NUMBER 890798320	

PROCEDURE DATE 11-6-19 PROCEDURE LENGTH ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT:

Upper Endoscopy

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 _____

☐ 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

PRE-SURGICAL TESTING ORDERS ☒ OTHER None

☐ 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 NONE

ALLERGIES ☑ None Known ☐ LATEX ☐ METAL ☐ OTHER _____

ALLERGIC REACTION _____

MEDICATIONS PREOPERATIVELY NONE **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: K. Kazbay **TIME:** 2:50pm **DATE:** 11.01.19

STAFF SIGNATURE/PRINTED NAME: Valentin **TIME:** 2:50pm **DATE:** 11.01.19