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FAX COVER SHEET

To: IN

From: Tamara DenDanto

Company: ORMC

To Fax Number: 3331041

Fax Reference ID: TDE5E4EAE949FE0

Date: 2/20/2020 4:06:40 PM

# of pages [incl. cover]: 2

Notes/Comments:

From Fax Number:

Sender Mailing Address: 155 Crystal Run Road

Middletown, NY 10941

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: Chakara Baggett	DOB: 12-19-79 SEX:	Diagnosis: Atherosclerosis with claudication
ADDRESS: 13 High Street	Surgeon: Fariant	Assistant:
Monticello, NY 12701	CPT CODE	ICD 10 CODE: I70.23 PRE-CERT #:
HOME NUMBER: 845-245-1519 CELL NUMBER	INSURANCE CO: MVP Medicare	INSURANCE ID NUMBER: 9088970700
PROCEDURE DATE 3/16/20 PROCEDURE LENGTH 3.0	X LEFT ☐ RIGHT ☐ BILATERAL	☐TRIAL PRODUCT
PROCEDURE ORDER FOR CONSENT:		
Left lower Extremity Femoral to Anterior tibial Bypass with saphenous vein		

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 ☐ High Health Risk: ☐ A ☐ B ☐ C ☐ D

Cilostazol - continue

☐ Medical /Cardiac Consultation by Dr. JAFRI 2.27 Anesthesia Consultation Requested ☐ Yes ☐ No

MEPS cardio

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) 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: _____ **TIME:** 1145 **DATE:** 2.17.20

STAFF SIGNATURE/PRINTED NAME: _____ **TIME:** 1145 **DATE:** 2.17.20

Ext 4671