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FAX COVER SHEET

To: ORMC In Bound

From: McDonnell-Benjamin, Erin

Company:

To Fax Number: 8453331041

Fax Reference ID: emc5E46BB3B98F5

Date: 2/14/2020 3:22:32 PM

of pages [incl. cover]: 2

Notes/Comments:


Surgery 2/18/2020-Dr. Trapp

From Fax Number:

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

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Revised for EST orders
EMB 2/14/2020

 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>Andrew, Kevin</u>		DOB: <u>4/26/58</u>	SEX: <u>male</u>	Diagnosis: <u>Primary Osteoarthritis R/L Hip</u>	
ADDRESS: <u>701 East Peenack Trail</u>		Surgeon: <u>TRAPP</u>		Assistant: <u>C. CASSIDY, PA-C</u>	
<u>Sparrowbush, NY 12780</u>		CPT CODE: <u>27130</u>	ICD-10 CODE: <u>M16A1</u>	PRE-CERT #:	
HOME NUMBER: <u>845-774-6744</u>	CELL NUMBER:	INSURANCE CO.: <u>Fidelis</u>	INSURANCE ID NUMBER: <u>74350606000</u>		
PROCEDURE DATE: <u>2/18/2020</u>		PROCEDURE LENGTH: <u>90 min</u>		<input type="checkbox"/> LEFT <input checked="" type="checkbox"/> RIGHT <input type="checkbox"/> BILATERAL <input type="checkbox"/> TRIAL PRODUCT	
PROCEDURE ORDER FOR CONSENT: <u>Total hip arthroplasty R/L</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:

☒ PST MEPS being done at ☐ ORMC ☒ CRHC ☒ MEPS Consultation by Dr. JOIS

☐ 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 HbA1C/HgA1C @ CRHC

☒ I & S only # OF UNITS: ☒ CBC ☒ BMP ☒ CMP ☒ PT/INR PT MSSAMRSA screen/culture ☐ UA ☒ 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 100mL/hr ☐ 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: K. Trapp, MD TIME: 5:00 DATE: 1/13/2020

STAFF SIGNATURE/PRINTED NAME: Frank McDermott-Benjamin TIME: 5:00 DATE: 1/13/2020

x3587



Orders/Surgical Scheduling/Department of Surgery and Medicine/December, 2018