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FAX COVER SHEET

To: ORMC

From: Noreen Maloney

Company:

To Fax Number: 3331041

Fax Reference ID: NMA5E384FB78FC5

Date: 2/3/2020 4:52:04 PM

# of pages [incl. cover]: 3

Notes/Comments:

DOS 02/11/2020

Dr. Karpoff

Please call patient to schedule PST appt..

Thank you

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: Joseph Duarte Jr. DOB: 6/21/68 SEX: M Diagnosis: Inguinal Hernia without obstruction or gangrene.

ADDRESS: 21 Picadilly Circle Rock Hill, NY 12775 Surgeon: KARPOFF Assistant: SCHEURER NP

CPT CODE 49650 ICD-10 CODE K40.90 PRE-CERT #:

HOME NUMBER CELL NUMBER 845-772-1872 INSURANCE CO. Hdelws INSURANCE ID NUMBER 743646147-00

PROCEDURE DATE 2/11/20 PROCEDURE LENGTH 35 MINS ☐ LEFT X RIGHT ☐ BILATERAL ☐ TRIAL PRODUCT

PROCEDURE ORDER FOR CONSENT:

Right INGUINAL HERNIA REPAIR WITH MESH

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

TYPE OF ADMISSION: X ORMC ☐ POB ☐ 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 ☐ 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 C. FINNIGAN FNP

☐ PST MEPS being done at ☐ ORMC ☐ CRHC ☐ MEPS Consultation by Dr. _____ Diagnosis _____

X PST Nurse only – patient NOT on insulin or anticoagulant

☐ PST Phone Assessment only – (does not stratify / NOT on insulin or anticoagulant) X

DIABETIC ☐ Yes X No ON INSULIN ☐ Yes X NO ON ANTICOAGULANT ☐ Yes X No Type _____ HISTORY SLEEP APNEA ☐ Yes X No

PRE-SURGICAL MEDICAL EVALUATION

Surgical Risk: ☐ Minimal X Low ☐ Intermediate or High Health Risk: ☐ A X B ☐ C ☐ D

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

PRE-SURGICAL TESTING ORDERS ☐ OTHER _____

☐ T & S # OF UNITS _____ X CBC X BMP (CMP) ☐ PT INR ☐ PTT ☐ MSSA/MRSA screen culture ☐ U/A X 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

X LR at 100ml/hr ☐ NS at 100ml/hr ☐ LR at KVO ☐ Other IV fluid _____ X Saline lock with NS flush

☐ KUB X-Ray upon arrival to Pre-Op X Intraop Venodyne ☐ Intraop Foley ☐ Additional Orders _____

ALLERGIES ☐ None Known ☐ LATEX ☐ METAL X OTHER Aspirin Lip Swelling

ALLERGIC REACTION _____

MEDICATIONS PREOPERATIVELY FOR ERAS Patients ☑ follow ERAS medication order protocol

☑ FOR TOTAL JOINT Patients follow Total Joint Protocol X Cefezolin (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: H. KARPOFF MD TIME: 4PM DATE: 2/3/20

STAFF SIGNATURE/PRINTED NAME: N. Mahoney TIME: 445PM DATE: 2/3/20

386284 703-6477

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

PO APPT scheduled 3/2 1:00

Joseph Duarte Jr.

Pt. Label

6/21/68

ORANGE REGIONAL MEDICAL CENTER

Consent for Surgical/Invasive Procedures and Sedation

I hereby give my consent and authorize: Dr. Karpoff and those who he/she may designate as associates or assistants to perform upon me or the named patient the following operation/procedures: Right; **INGUINAL HERNIA REPAIR WITH MESH**

The nature, intended purpose, benefits, significant foreseeable risks, complications and consequences of such operation/procedure, as well as the alternatives if the above operation/procedure is not performed, have been explained and discussed with me by (Name of Physician): Dr Karpoff.

I give permission with full knowledge and understanding thereof. I understand that medicine is not an exact science and that there is the possibility that the operation/procedure may not have the benefits or results intended. I am also aware that there are always risks and dangers to life and health associated generally with surgery, use of medication, medical procedures and treatments which can cause adverse consequences not ordinarily anticipated in advance, but I give this permission with full assent nevertheless.

It has been explained to me and I understand that during the course of the operation/procedure, unforeseen conditions may be revealed or encountered which necessitate surgical or other procedures in addition to or different from those contemplated. I therefore request and authorize the above named physician or his/her designees to perform such additional surgical or other procedures as are deemed necessary or desirable.

- I understand that the procedure may require that I undergo some forms of sedation, which may have its own risks. Prior to my procedure my doctor will inform me of the course of sedation that is recommended (if any) along with its risks, benefits, discomforts, and potential complications.
- I consent to photographing, videotaping, televising or other observation of the operation/procedure/treatment as may be purposeful for the advance of medical knowledge and/or education, with the understanding that my/the patient's identity remain anonymous and all photographs and videotapes remain the property of ORMC and/or the responsible physician.
- I consent to the presence of Vendors/Salespersons/Students during the procedure/operation.
- I consent to the administration of blood/blood components if deemed necessary. The Surgeon has explained to me the need for, risks of and alternatives to blood transfusion if blood or blood components are needed.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the procedure(s) specified above.

2/3/2021 AM/PM — (Date) (Time) — (Patient/Health Care Agent/Surrogate/Guardian Signature) — Joseph Duarte Jr. (Printed Name) — Self (Relationship to patient)

2/3/2021 AM/PM — (Date) (Time) — (Witness Signature) — (Printed Name)

Mark this box if telephone consent ☐ Mark this box if interpreter was involved ☐ _____ (Interpreter ID#)

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the procedure, the alternatives, including not performing the procedure, as well as the risks and benefits of the alternatives; and I am satisfied that the patient or patient's legal representative who signed above understands them.

2/3/2021 AM/PM — (Date) (Time) — (Signature of Physician/Appropriately Credential Practitioner Providing Explanation) — Lt Karpoff (Printed Name)