Pre-Operative Surgery Clearance

___Primary Care Physician ___Cardio ___Pumonary ___Other:_____

Dear Dr._____

Patient Name:_____DOB:_____ is scheduled for the following surgical procedure:

_____on _____/_____/_____.

We are requesting a medical evaluation for surgical clearance. Please complete and fax to our office along with any pre-operative testing results. Should this patient require an extensive physical that cannot be completed before the scheduled surgery date, please notify our office and we will accommodate the patient with a new surgery date. I greatly appreciate the opportunity to work with your patients.

The following labs are required for surgery:

- **CBC, Chemistry 10, Coags, Albumin/Transferrin, CRP/ESR**

Urinalysis – if positive and performed by your primary care provider, this should be treated

The following labs / diagnostic studies must be done at the hospital:

- **Type & Screen, MRSA Nasal Screening, Chest X-Ray, EKG, Urinalysis (if not done by primary care)**

Your H&P (history and physical) (optional H&P handout attached) can be completed by your primary care, but you will need to bring a copy to pre-admission testing.

SEE NEXT PAGE →

PLEASE SEND COPIES OF MOST RECENT OFFICE NOTE, LABS, CHEST X-RAY, EKG, & STRESS TEST IF NECESSARY AND INSTRUCTIONS ON BLOOD THINNERS IF APPLICAPLE TO: F:** 804-968-1816

( ) Pt is medically cleared for surgery

_____/_____/_____ _____

(Signature of Provider or Specialist) (Date) (Please print provider name)

Specific Recommendations following surgery

:_____

_____

( ) Pt is NOT medically cleared for surgery:

(Concerns):_____

_____

Thank You for allowing me to care for your patient!

Ryan N. Robertson, MD – Please call my cell (804) 690-7973 for any questions

Preop H&P

Ryan N. Robertson, MD
Telephone: 804-288-1802 ext 11073
Fax: 804-968-1816

Name_____
MRN_____
DOS_____

History of Present Illness:

_____

Medications:

_____

_____

_____

Allergies:

_____

_____

General:_____

_____

_____

HEENT: Normal ( )
Chest: Normal ( )
Abdomen: Normal ( )
Genitalia/Rectal: Normal ( )
Extremities: Normal ( )
Neurological: Normal ( )

Notes:_____

_____

Impression:_____

_____

Recommendations:

_____

_____

Cleared for Surgery: Yes ( ) No ( )

Date/Time:_____
Signature:_____