



PRE-OPERATIVE MEDICAL/CARDIAC CLEARANCE

Dear Doctor _____,

Your patient has been scheduled for surgery at the center identified above. The patient's surgeon /Anesthesiologist have requested a medical and/or cardiac clearance from you to be returned via fax to: **(248) 423-5125** as soon as possible prior to the proposed surgical date. If you have any questions regarding this request or if you wish to speak with an Anesthesiologist, you can do so at **(248) 423-5117**.

Thank you for your assistance,

Pre-Anesthesia Surgical Screening

Patient Name: _____

Date of Surgery: _____ Surgeon: _____

Surgical Procedure: _____

Please be aware the patient will need to hold the following medications for the identified period of time. If you have any concerns regarding the management of these medications, please contact the Pre-Anesthesia Surgical Screening Department at the number above.

Plavix - 7 days Aspirin - 7 days Coumadin - 5 days Lovenox - 24 hours

Other: _____

✓ Indicates labs or diagnostics needed before surgery can be scheduled:

The hospital will accept lab reports (obtained within 30 days) or diagnostics (obtained in the last 6 months).

CBC Electrolytes BUN/CR PT/PTT/INR Blood Glucose UA /C&S

EKG Chest X-Ray Stress Test Pacemaker interrogation Echocardiogram

Please provide the following:

- The patient is medically cleared for surgery YES NO LETTER
- The patient is cardiac cleared for surgery YES NO LETTER
- Please list any co-morbidities the patient is actively being treated for:

Physician Name: _____

Physician Signature: _____

Date: _____