Medical Clearance for Surgical Procedure

Vernon Square SurgiCenter
230 Center Dr
Vernon Hills, IL 60061 (847) 367-8764

Patient Name:_____ DOB: _____

Operating Surgeon:_____Diagnosis:_____

Procedure & Date: _____

Anesthesia Type: o General o IV Sedation o Spinal/Epidural o IV Block o Nerve Block o Local o LMA

Office stamp of Primary Care Physician or Specialist Providing H & P and/or Clearance:

Vital Signs: PULSE:_____TEMP.:_____BP:_____RR:_____HT.:_____WT.:_____

Review of Systems

(-)	(+)		POSITIVE FINDINGS EXPLANATIONS
o	o	CARDIOVASCULAR*	o Pacemaker O AICD Type:
			_____ **Congestive Heart Failure** / _____ **Hypertension** / _____ **Heart attack** / _____ **Murmur** / _____ **A-fib** / _____ **Pacemaker** / _____ **Other**:_____
o	o	RESPIRATOR/PULMONARY	_____**Asthma** / _____ **COPD** / _____**TB** / _____**Sleep Apnea** / _____**Recent URI** / _____**Smoker** _____ # of packs
o	o	GASTROINTESTINAL	_____**GERD** / _____ **IBS** / _____ **Constipation** / _____ **Diarrhea** / ____ **Ulcers**
o	o	RENAL	_____**Dialysis** / _____ **Kidney Disease** / _____ **Kidney Stones** / _____ **PCKD**
o	o	MUSULOSKELETAL	**Specify:**
o	o	INTEGUMENTARY	**Specify:**
o	o	NEUROLOGICAL/MENTAL	_____**Alcohol: Y or N** _____ **# of drinks** / _____**Drugs: Y or N** / _____**Depression**
o	o	ENDOCRINE	Diabetes Current TX: _____ **Insulin** / _____ **Oral** / _____**Diet** / _____ **Thyroid** / _____ **Hypo/Hyper** _____**Sx**:
o	o	HEMATOLOGIC LYMPH	**Specify:**
o	o	IMMUNOLOGICAL	**Specify:**
o	o	Gynecological	_____**N/A** / _____ **Hysterectomy** # of years ago_____ / **LMP** _____

Please attach last cardiology office letter, recent stress and/or echo test results, and EKG

Tests ordered: EKG _____CXR_____CBC_____BMP_____UA_____PT/PTT_____

Add'l Labs/Tests ordered: _____

Allergies: **___Latex / ___Sulfa / ___ PCN / ___ Iodine / ___ Hydrocodine / ___Tape / ___ Other:**

_____

_____

Surgical History

Surgery	Year	Complication

Current Medication List

or

____See Attached Medication List

Name	Dosage	Frequency

If patient is on Coumadin, can it be stopped? _____ NO / _____ YES if yes # of days prior to surgery _____

Should Patient continue on all medications for this procedure? _____ Yes / _____ No

If No, Please Specify the medication changes by medication and instructions:

Medication	Change	Stop	# days	Restart

PATIENT CLEARED FOR PROPOSED SURGERY: o YES o NO

_____ _____ _____

Physician's Signature: Print Physician's Name: Date:

Office stamp of Primary Care Physician or Specialist Providing H & P and/or Clearance:

Please FAX Form to: **Vernon Square Surgicenter: (847) 367- 5782**