# Vernon Square Surgicenter Vernon Hills IL

**Medical Clearance for Surgical Procedure**

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

Constitutional: PULSE: TEMP.: BP: RR: HT.: WT.:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | (-) (+) POSITIVE FINDINGS | (+) |  | | **POSITIVE FINDINGS EXPLANATIONS** | |
| **Review of Systems** | o | o | CARDIOVASCULAR\* | | o Pacemaker | O AICD Type: |
| Congestive Heart Failure / O- Hypertension / O-Heart attack / O-Murmur / O-A-fib / O-Pacemaker | | | Congestive Heart Failure / Hypertension / Heart attack / Murmur / A-fib / Pacemaker | | |
| 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 | |  | |
| o | o | INTEGUMENTARY | |  | |
| 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 | |  | |
| o | o | IMMUNOLOGICAL | |  | |
| 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

Drug Allergies Reactions:  **Latex** / **Sulfa** / **PCN** / **Iodine** / **Hydrocodine** / **Tape**

**If patient is on Coumadin, can it be stopped? \_ Yes \_ No If Yes,# \_\_\_\_days before surgery.**

|  |  |  |
| --- | --- | --- |
| **Surgery** | **Year** | **Complication** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Current Medication (additional room on back) \_\_See Medication List Attached

|  |  |  |
| --- | --- | --- |
| **Name** | **Dosage** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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

Stop Medications? Yes / No, If Yes, which meds & how many days prior to surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT CLEARED FOR PROPOSED SURGERY:** o **YES** o **NO**

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Physician’s Signature: Print Physician’s Name: Date:

Please FAX Form to: **Vernon Square Surgicenter: (847) 367-8764**

# \*Failure to receive this back in a timely manner may result in the surgery being delayed or canceled\*