ST JOHN PROVIDENCE HEALTH SYSTEM® PROVIDENCE

Pre-Surgical Medical Evaluation / Clearance Form

PLEASE FAX THIS FORM TO PROVIDENCE PRE-SURGICAL SCREENING AND REQUESTING SURGEON NO LATER THAN:

_____ **Date**

(Clearance is good for 60 days prior to surgery)

Patient: _____ **Birth Date:** _____

Surgeon: _____ **Surgery Date:** _____

Proposed Surgery / Procedure: _____

Locations:

☐ Providence Hospital - Southfield	Fax: (248) 849-5487	Phone: (248) 849-3089
☐ Providence Park Hospital - Novi	Fax: (248) 465-4071	Phone: (248) 465-4070
☐ Requesting Surgeon	Fax: _____	Phone: _____

PRIMARY/CONSULTING PHYSICIAN

Internist, Cardiologist, etc.

Physician Name (print): _____

***Phone:** _____ **Fax:** _____

Please check boxes and forward all applicable diagnostic test results:

- ☐ EKG (within 6 months of surgery)
- ☐ Labs (within 30 days of surgery)
- ☐ Chest x-ray (most recent within 30 days of surgery)
- ☐ Stress Test
- ☐ Heart Catheterization
- ☐ Echocardiogram
- ☐ Pacemaker check with thresholds
- ☐ Other: _____

Patient's Major Medical Problems:

_____
_____
_____
_____
_____
Allergies: _____
_____

Current Medications / Dose / Frequency: ☐ See Attached

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Comments: _____

_____

PATIENT'S CONDITION WILL PERMIT THE PROPOSED SURGERY:

- ☐ YES
- ☐ NO. Rationale: (please describe) _____

_____

Physician Name (print): _____ Date: _____ Time: _____

Physician Signature: _____