Medical Clearance Form for Surgery

Patient Identification

Name: _____

Age: _____

Gender: [ ] Male [ ] Female [ ] Other

Contact Info: _____

Surgical Information

Type of Surgery: _____

Scheduled Date: _____

Surgeon Name: _____

Pre-operative Assessment

Medical History Review:

_____

_____

Surgical Clearance

Clearance Status: [ ] Cleared [ ] Not Cleared

Reason if not cleared: _____

Signature of Medical Officer: _____

Date: _____