Pre-Operative Clearance Form

Dr. Julious (Jody) P. Smith, III

Instructions to Patient

Please take this form to your Primary Care Physician (PCP) to be completed at the time of your pre-surgery exam.

Schedule your appointment with your PCP at least 2 weeks prior to surgery, but no longer than 30 days before surgery.

Your PCP will fax the completed form back to our office.

History and Physical/Clearance Exam

Thank you for your referral of patients to our practice. Your patient needs a surgical procedure and it is required for them to have a pre-operative history and physical/clearance exam and diagnostic tests. The following tests are required prior to surgery.

- CBC
- BMP
- PT/INR
- UA with reflux culture
- EKG (if patient < 50 only if cardiac history)
- Hgb A1c

Please fax all test results along with this completed form to our office. If you have an electronic health record, you may use it instead of this form but you must address all areas. If you are unable to complete the above diagnostic testing it will be done at the St. Mary's Hospital Pre-admission Testing appointment. They will also obtain a Type and Screen and MRSA/MISSA nares culture.

Name: ____

Date: ____________________

Rx: Consult for Medical Clearance

Dx: Surgery ____

PAT Date: _______________________

Signature of Provider: _____________________

Please fax completed form (both pages) and test results to 804-287-2796.

If you have any problems or questions, please call your doctor's office (8am-5pm).

Answering service for after hours.

5899 BREMO ROAD, SUITE 100A
RICHMOND, VA 23226
P 804.915.1910 | F 804.287.2976
ORTHOVIRGINIA.COM

Name: ______________________________ Surgical Date: __________________

Surgical Procedure: ____

Date of Birth: _____________________________________ Male: _____ Female: _____

Height: ____________ Weight: ____________ Blood Pressure: ______________________________

Past Medical History

Diabetes: ______ Lung Disease: ______ Heart Disease: ________

Seizure: ________ Hypertension: ______ Cancer: ______________

Medications:

_________________ _________________ _________________

_________________ _________________ _________________

_________________ _________________ _________________

Past Surgical History: ____

Family History: ____

Social History: ____

Review of systems/Examination

General Appearance: ____

HEENT: ____

Respiratory: ____

C-V: ____

G-I: ____

Abdomen: ____

GYN: ____

Musculoskeletal: ____

Neurological: ____

________ Surgery Recommended ______________ Surgery NOT Recommended

MD Signature: ____ Date: __________________

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Stronger starts here.

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