Patient Name: ______________________________

Patient Birthdate: ________________

OR affix Patient Label

GRAND VIEW HOSPITAL
700 Lawn Avenue
Sellersville, PA 18960

MEDICAL CLEARANCE FOR SURGICAL OR MEDICAL PROCEDURE

Please FAX back to: ______________________ (Surgeon Office)
Failure to receive this back in a timely manner may result in the surgery being delayed

Patient Name: ____ Date of Birth: ________________

Operating Surgeon: ____ Diagnosis: __________________

Procedure & Date: ____

Anesthesia Type: ☐ General ☐ TIVA ☐ Spinal/Epidural ☐ IV Block ☐ Nerve Block ☐ Local ☐ LMA

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

(-)	(+)	SYSTEMS	POSITIVE FINDINGS
☐	☐	CARDIOVASCULAR	pacemaker ☐ AICD ☐ type:
☐	☐	RESPIRATORY	
☐	☐	GASTROINTESTINAL	
☐	☐	GENITOURINARY	
☐	☐	MUSCULOSKELETAL	
☐	☐	INTEGUMENTARY	
☐	☐	NEUROLOGICAL/MENTAL	
☐	☐	ENDOCRINE	
☐	☐	HEMATOLOGIC LYMPH	
☐	☐	IMMUNOLOGICAL	

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

Recommendations for peri-operative care:

____

____

Tests: Within 6 months EKG _________ CXR _________

Within 6 weeks CBC _________ BMP_________ UA_________ PT/PTT_________

Drug Allergies Reactions:
☐ MRSA
☐ Latex
☐ ____

If patient is on Coumadin, can it be stopped?
☐ Yes ☐ No
If Yes, ____________days before surgery.

CLEARED FOR PROPOSED SURGERY: ☐ **YES** ☐ **NO**

Print Physician's Name: ______________________________________

Physician's Signature: **Date:** **Time:**