GENERAL MEDICAL CONSULTANTS

Phone: 614-221-3725
Fax: 614-221-5613 or 614-961-1097

PREOPERATIVE MEDICAL CONSULTATION REQUEST

PATIENT DEMOGRAPHICS:

NAME: _____ **DOB:** ____/____/_____

PHONE: _____ ☐ **INSURANCE CARD COPY INCLUDED**

ADDRESS: _____

REQUESTING PHYSICIAN: _____

SURGERY DATE: ____/____/_____ **SURGICAL FACILITY:** _____

PROCEDURE: _____ **SURGICAL DIAGNOSIS:** _____

REQUESTED CONSULTATION TO INCLUDE:

- ☐ Assessment and Optimization of Documented Medical conditions as indicated below.
- ☐ Optimization/Treatment to include necessary diagnostic testing and Preoperative medication management for the above planned procedure.
- ☐ Arrangement of additional Clearance (i.e., Cardiology) when necessary.
- ☐ Report will be sent to the Requesting Surgeon and Surgical Facility, unless otherwise indicated.

CLINICAL REASONING/DIAGNOSIS FOR SURGICAL PRE-EVALUATION:

- ☐ OTHER - _____
- ☐ Anemia
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Atrial Fib
- ☐ Benign Prostatic Hypertrophy
- ☐ Coronary Artery Disease
- ☐ Cardiac Murmur
- ☐ Congestive Heart Failure
- ☐ Chest Pain
- ☐ Chronic Kidney Disease
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Cerebral Vascular Accident
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Dyspnea
- ☐ EKG (Abnormal)
- ☐ Elevated BP
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gastroesophageal Reflux Disease
- ☐ History of Anesthesia Complications
- ☐ History of DVT
- ☐ History of Surgical Complications
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Neuropathy
- ☐ Nicotine Dependence
- ☐ Obesity BMI >30
- ☐ Obesity, Morbid BMI >40
- ☐ Obstructive Sleep Apnea
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Thrombophilia
- ☐ Transient Ischemic Attack
- ☐ Venous Insufficiency

ADDITIONAL DOCUMENTATION INCLUDED:

- ☐ Requesting Provider Note
- ☐ Prior testing

_____ _____
Referring Provider Signature Date

CONSULT SCHEDULED:

DATE: _____TIME: _____ PATIENT NOTIFIED by _____