

GENERAL MEDICAL CONSULTANTS, INC.

Phone: (614) 221-3725

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PREOPERATIVE MEDICAL CONSULTATION REQUEST

PATIENT NAME: _____

PATIENT DOB: ____/____/____

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:

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

ADDITIONAL DOCUMENTATION INCLUDED:

- Requesting Provider Note
- Prior testing

Referring Provider Signature _____

Date _____

CONSULT SCHEDULED:

DATE: _____ TIME: _____ PATIENT NOTIFIED by _____