STEVEN F. HARWIN, MD, FACS
Chief of Adult Reconstructive Surgery – Beth Israel Medical Center

PRE-OPERATIVE CLEARANCE — *GIVE TO YOUR PRIMARY CARE DOCTOR*

Please fax to our surgical coordinator, Lucy Padilla, at (718) 655-3047

PATIENT: ______________________________ DATE OF BIRTH: ____________________

OPERATION: ______________________________ DATE OF SURGERY: ____________________

HISTORY: ____

____

PMH ____

____

PSH ____

ROS ____

FH ______________________________ SH ______________________________

Meds ____

____

Allergies ____

PHYSICAL EXAM: BP ____________ P ____________ RR ____________ T ____________

HEENT ________________ NECK ________________ HEART ________________

LUNGS ______________________________ ABDOMEN ______________________________

EXTREMITIES/NEURO ______________________________ PELVIC/RECTAL ____________________

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____

____

DIAGNOSIS: ____

____

LABS ______________________ ☐ attached EKG ______________________ ☐ attached

____

CHEST X-RAY ______________________________ U/A ______________________ ☐ attached

IMPRESSION:
- ☐ There is no medical contraindication to planned surgery (ASA Class ____________)
- ☐ The patient is not cleared for surgery
- ☐ Additional treatment, work-up, consultation or clearance needed: ____________________

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PHYSICIAN (PRINT) ______________________________ **SIGNATURE** ______________________________

ADDRESS ____

TEL: ____________________ **FAX:** ____________________ **DATE OF EXAM** ____________________