OUT-PATIENT SURGERY PRE-OPERATIVE CONSULTATION FORM

Patient ____

Date of Birth ____

Date of Consultation ____

Surgeon requesting consultation _______________________________________

HISTORY

Chief Complaint/History of Present Illness ______________________________________
____
____
____
____

Review of Systems					
Constitutional	neg	pos	Musculoskeletal	neg	pos
Eyes	neg	pos	Skin	neg	pos
ENT/Mouth	neg	pos	Neurologic	neg	pos
Cardiovascular	neg	pos	Psychiatric	neg	pos
Respiratory	neg	pos	Endocrine	neg	pos
Gastrointestinal	neg	pos	Heme/Lymphatic	neg	pos
Genitourinary	neg	pos	Allergy/Immunol	neg	pos

Describe any positive responses____
____
____

Past Medical/Surgical History ____
____
____

Current Medications and Dosages ____
____
____

Allergies____

Family History____

Social History____

EXAMINATION

Vital Signs P__________reg/irreg BP _________________ Temp _______________

Weight _________________ Height ________________ Resp __________________

General Appearance ____

Eyes	WNL	ABN	not done
ENT/Mouth	WNL	ABN	not done
Neck	WNL	ABN	not done
Respiratory	WNL	ABN	not done
Cardiac	WNL	ABN	not done
Breasts	WNL	ABN	not done
Abdomen	WNL	ABN	not done
Genito-Urinary	WNL	ABN	not done
Lymph	WNL	ABN	not done
Musculoskeletal	WNL	ABN	not done
Skin/subQ tissue	WNL	ABN	not done
Neurologic	WNL	ABN	not done
Psychiatric	WNL	ABN	not done

Describe abnormal findings ____
____
____

RECOMMENDATIONS

Is patient medically cleared for surgery? ______Yes ________No
Lab results pending____
Lab results reviewed____
Any change in medications for this procedure? ______Yes ______No
If yes, what changes? ____
____

Other recommendations____
____
____

Thank you for allowing me to render a consultation on this patient.

Sincerely, ____
(Signature)
Please print name____
Date Consult form was sent to the requesting physician__________________________
Preoperative Testing Needed:
____ EKG (within 1 year) ____ BMP (includes Potassium, Sodium, Glucose, BUN
____ Chest X-Ray ____CBC
Please fax back to (717)-431-2540