OUT-PATIENT SURGERY PRE-OPERATIVE CONSULTATION FORM

Please **fax back to** (717)735-6894(pre anesthesia office) and____________(surgeon).

- Consultation to be completed within 30 days of surgery and received by pre-anesthesia department/ surgeon 3 days prior to surgery

Surgeon requesting _________________________ Date of surgery______________

Patient Name ______________________________Date of Birth ________________

Reason for consultation/procedure ____

Physician Name____________________________ Date of 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/Immunological	neg	pos

Describe any positive responses:____

____

____

Past Medical/Surgical History ____

____

Current Medications and Dosages ____

____

Allergies____

Family History ____

Social History ____

Name: Date of Birth:

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 ____

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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? ____

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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 6 months) ______BMP (includes Potassium, Sodium, Glucose, BUN

_____ Chest X-Ray (within 1 month) ______ CBC