PRE-OP CLEARANCE REQUISITE

95 UNIVERSITY PLACE / 8TH FLOOR / NEW YORK, NY. 10003
Tel: 212-604-1367 Fax: (212) 400-3949

PLEASE ENSURE THAT YOU BRING YOUR INSURANCE INFORMATION WITH YOU TO YOUR MEDICAL CLEARANCE APPOINTMENT, WE ARE NOT ABLE TO FAX THIS. THE PATIENT IS RESPONSIBLE TO PROVIDE THIS INFORMATION TO ALL PROVIDERS. THANK YOU

Please fax all test results Att: AMANTINA 212-400-3949

Dr. _____,

_____ is scheduled for _____ surgery at on _____. The anesthesia department requests that the following preoperative tests be performed prior to the surgery.

____ CBC with differential

____ Basic Metabolic Panel

____ Hepatic Profile

____ PT

___ PTT

___ Urinalysis

___ Urine Pregnancy

___ EKG

___ CXR

___ Medical Clearance

In addition, if the patient presents with a new or worsening medical condition please perform all tests necessary to clear the patient for the up coming surgery.

Thank you,

Dr. Richard M. Seldes
Shoulder, Knee & Hip Specialist
Board Certified Orthopaedic Surgeon