



**Surgeons Choice Medical Center**

22401 Foster Winter Dr.

Southfield, MI 48075

Ph: 248-423-5117 Fax: 248-423-5195

**Surgeons Choice Medical Center**

11012 Thirteen Mile Road

Warren, MI 48093

DR. \_\_\_\_\_

Your Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Is scheduled for surgery on: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Procedure: \_\_\_\_\_  
\_\_\_\_\_

The Surgeon/Anesthesiologist is requesting medical/cardiac clearance to determine appropriate management of the patient.

is patient medically stable for surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

Is patient in stable cardiac condition for surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

**IS PATIENT ABLE TO STOP THE FOLLOWING MEDICATIONS FOR THIS PROCEDURE? YES OR NO**

**IF YES, FOR HOW MANY DAYS PRE-OP?**

\_\_\_\_ Aspirin \_\_\_\_\_

\_\_\_\_ Coumadin \_\_\_\_\_

\_\_\_\_ Plavix \_\_\_\_\_

\_\_\_\_ Xarelto \_\_\_\_\_

\_\_\_\_ Pradaxa \_\_\_\_\_

\_\_\_\_ Eliquis \_\_\_\_\_

\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_ Brilinta \_\_\_\_\_

Please supply (if available): **RECENT EKG**

**CARDIAC TEST RESULTS**

**LAB WORK**

**LAST PACEMAKER CHECK**

Comments; \_\_\_\_\_

\_\_\_\_\_

Physician name/signature \_\_\_\_\_ Date: \_\_\_\_\_

Thank you, Presurgical Screening Dept.