



Pre-Operative Clearance request form

Patient Information

Attorney Information

Name:	Attorney Name:
Date of Birth:	Phone number:
Phone Number:	Email address:
Address:	Case Manager:
Email Address:	Email address:
Date of Accident:	Law firm:

Surgery Information

Date of Surgery:
Surgical Procedures:
Type of Anesthesia:
Surgery Center:

Please indicate which tests need to be included for pre-op clearance:

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> CBC | <input type="checkbox"/> CMP |
| <input type="checkbox"/> Urinalysis | <input type="checkbox"/> PT & PTT |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Chest X-Ray |
| <input type="checkbox"/> Beta HCG Quantitative | <input type="checkbox"/> Other: _____ |

Referral Source Information:

Name:	Fax Number:
Phone Number:	Contact Person:
Contact Email Address:	Surgeon Name:

SURGICAL CLEAR

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