

January 26, 2010

RE: _____ Surgical Procedure: _____

DOB: _____ Surgery Date: _____

PRE-SURGICAL TESTING REQUIREMENTS

PRE-OP TESTING TO BE DONE 20 - 30 DAYS PRIOR TO SURGERY DATE:

- HISTORY & PHYSICAL (form attached)
- CBC
- COMPREHENSIVE METABOLIC PANEL
- PT, PTT
- URINALYSIS

PATIENTS AGE 45 AND OVER and/or any HISTORY OF LUNG/HEART CONDITIONS:

- EKG (strip & written interpretation)
- CHEST X-RAY

FEMALE PATIENTS AGE 55 AND YOUNGER WHO HAVE NOT HAD A HYSTERECTOMY:

- URINE PREGNANCY TEST

CARDIAC TESTING: REQUIRED FOR ALL PATIENTS WHO HAVE ANY CARDIAC HISTORY

- INCLUDING ABNORMAL EKG OR STRESS TEST
- ANY PATIENT OVER THE AGE OF 75
 - PATIENT WILL BE REQUIRED TO OBTAIN CLEARANCE LETTER FROM A CARDIOLOGIST
 - ALL CARDIAC TESTING (STRESS TESTS, ECHO, EKG...) MUST BE FAXED TO OUR OFFICE

H&P and Labs are good for 30 days ~ EKG & Chest X-ray (if normal) are good for 6 months

Please call 410-601-0714 as soon as possible if you have any questions or problems.



Harpal S. Khanuja, M.D.

MEDICAL CLEARANCE FOR SURGERY MUST BE RECEIVED in our office no later than
3 days before surgery

FAX ALL RESULTS TO 410-601-7811

*** IMPORTANT ***

Dr. Khanuja's NPI # - 1033187869

EXCEPTIONS WILL LEAD TO CANCELLATION OF PATIENT'S SURGERY!!

PREOPERATIVE ASSESSMENT FORM

Patient Name _____ Date _____

Date of Surgery _____ Proposed Surgery _____

Present Illness _____

CURRENT MEDICATIONS

Medication	Dosage	Frequency	Medication	Dosage	Frequency
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

ALLELARGIES _____

PAST SURGICAL HISTORY

Date	Surgery	Hospital Name	Complications
1)			
2)			
3)			
4)			
5)			

SOCIAL HISTORY: Smoking _____ Alcohol _____ Caffeine _____

REVIEW OF SYSTEMS - Check Box if Applicable and Circle Specific Condition If Multiple Choice

- | | | | |
|--|---|--|---|
| <u>Cardiovascular</u> <input type="checkbox"/> None
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Angina/chest pain
<input type="checkbox"/> MI/CAD
<input type="checkbox"/> Arrhythmia/Palpitations
<input type="checkbox"/> CHF
<input type="checkbox"/> Valve disease
<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> Pacemaker/AICD
<input type="checkbox"/> Cardiac surgery
<input type="checkbox"/> Coronary stents
<input type="checkbox"/> Poor exercise tolerance

<u>Anesthesia</u> <input type="checkbox"/> None
<input type="checkbox"/> Family hx of problems
<input type="checkbox"/> Prev Anes complications

<u>GYN</u>
LMP _____ | <u>Hematologic</u> <input type="checkbox"/> None
<input type="checkbox"/> Sickle cell disease/trait
<input type="checkbox"/> Coagulopathy
<input type="checkbox"/> Transfusion
<input type="checkbox"/> Accepts transfusion
<input type="checkbox"/> Anemia/blood loss anemia
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chemotherapy

<u>GI/Renal/Endocrine</u> <input type="checkbox"/> None
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Diabetes I or II
<input type="checkbox"/> Obesity/morbid obesity
<input type="checkbox"/> Heartburn/Reflux
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Renal insufficiency
<input type="checkbox"/> Recent steroid use
<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Urinary tract infection | <u>Pulmonary</u> <input type="checkbox"/> None
<input type="checkbox"/> Asthma
<input type="checkbox"/> Smoking History
<input type="checkbox"/> COPD/emphysema
<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> SOB
<input type="checkbox"/> Cough/Productive cough
<input type="checkbox"/> Wheezing
<input type="checkbox"/> PND/Orthopnea
<input type="checkbox"/> Tuberculosis

<u>Neurologic/MS</u> <input type="checkbox"/> None
<input type="checkbox"/> TIA or Stroke
<input type="checkbox"/> Seizures
<input type="checkbox"/> Neuromuscular disease
<input type="checkbox"/> Cerebrovascular disease
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Dementia/Alzheimer's
<input type="checkbox"/> Elevated ICP
<input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Back problems
<input type="checkbox"/> Muscular dystrophy
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Syncope |
|--|---|--|---|

Comment on Positives or Symptoms not listed _____

PEDIATRICS Prematurity Congenital Anomaly Apnea Recent URI/illness

PHYSICAL EXAM

Ht	Wt	Temp	BP	P	R
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General appearance _____

HEENT PERRLA EOMI No Lymphadenopathy No JVD O/P WNL
 Thyroid WNL TM WNL

Abnormal:

Cardiovascular RRR S1S2 S3 S4

Abnormal:

Pulmonary Lungs CTA B/L

Abnormal:

GI Abd Benign - Normoactive BS No Hepatosplenomegaly

Abnormal:

Extremities No Clubbing No Cyanosis No Edema

Abnormal:

Musculoskeletal NML Muscle Tone NML Strength

Abnormal:

Neurological CN II-XII intact NML Mood

Abnormal:

Genitalia/Rectum No masses Heme negative

Abnormal:

ASSESSMENT: _____

The Surgery proposed for this patient is low / intermediate / high risk. The patient represents low / intermediate / high risk of cardiac mortality because of _____
minor / intermediate / major clinical predictors _____

- PLAN Further testing for this patient is not recommended. The patient may proceed directly to surgery.
 Further testing is recommended for this patient. Please obtain

_____ prior to planned surgery.

Physician/NP Name Printed _____

Signature _____ Phone Number _____

Anesthesia Provider _____