ENGLEWOOD SPORTS MEDICINE ORTHOPAEDIC SURGERY, P.C.

IMPORTANT OPERATIVE DETAILS

PATIENT NAME: _____

PHYSICIAN: _____

PROCEDURE: _____

SURGERY DATE: _____

LOCATION: _____

MAKE AN APPOINTMENT WITH YOUR FAMILY PHYSICIAN TO OBTAIN MEDICAL CLEARANCE/PRE-ADMISSION TESTING FOR:

- ◯ EKG/ECG (Good within 6 months)
- ◯ CBC
- ◯ CMP
- ◯ MRSA
- ◯ MRSA swab
- ◯ SMA 12/BMP
- ◯ PT/PTT
- ◯ CXR
- ◯ Urinalysis & culture
- ◯ Type & screen

ALL MEDICAL CLEARANCE/PRE-ADMISSION TEST RESULTS MUST BE EMAILED TO EKSM370@GMAIL.COM OR FAXED TO 201.567.8049 ONE WEEK PRIOR TO YOUR SCHEDULED SURGERY DATE.

YOUR RESULTS MUST BE FAXED ON OR BEFORE: _____

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