LSU Health System
Interim LSU Hospital in New Orleans

Patient Label/Stamp

Pre-OP Evaluation
(Referral For Medical Clearance)

Fax: 504. 903.1605

Primary Care Provider/Medical Home--INDICATE ALL THAT APPLY:

Community Clinics: ___Douglass ___Daughters of Charity ___Excelth, Inc.
___Henderson ___Jackson Barracks ___Jefferson Parish Community Health Center
___Martin Behrman ___New Orleans East ___St Charles Community Health Center
___St Thomas Clinic
Health Department : ___City ___State
LIH Medicine Clinic: ___LSU ___Tulane
__Other: _________________

Referring Surgeon: __________________ ID Number: _____________

If Patient Label/Stamp is Not Available Complete the Following:
Patient's Name: ____ Date of Referral: ____/____/____
Date of Birth: _____/______/_____ Medical Record Number: ____________________________________

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1˚ Contact Number: __________________________ **2˚ Contact Number:** ______________________________
Email Address: ____

V72.83 Pre-operative medical evaluation (All Primary Care Clinics)

PLEASE COMPLETE ALL OF THE FOLLOWING:

Date Surgery is scheduled: ___/___/___
Proposed Surgical Procedure: ____
Proposed Anesthesia: ___General ___Spinal/Epidural/Regional ___Modified Anesthesia Care(MAC)
Risk of Bleeding: ___High ___Intermediate ___Low
Co-Morbid Conditions:

___ASA/NSAID therapy	**___CAD/HF**	**___DM**
___HTN	**___Hx: CVA**	**___HX: DVT**
___Insulin therapy	**___Kidney Disease**	**___Lung Disease**
___Previous adverse reaction to Anesthesia		**___Tobacco use**

Pre-op work-up:

1. CBC, Platelet, CMP: all patients
2. PT, PTT, INR: for patients on Coumadin, Aggrenox, Plavix, or other anticoagulant medications, with known bleeding diathesis or known or suspected liver disease
3. EKG: for men> 40, women > 50, patients with known cardiac disease or diabetes
4. Lipid Profile & Hemoglobin A1C: patients with diabetes mellitus

Clinical History Relevant for this Referral: ____
____
____

Referring Provider's Signature: _________________________________ ID Number: __ __ __ __ __
Contact Number: __ __ __-__ __ __-__ __ __ __ Referring Service/Clinic: ___________________

OFFICE USE ONLY: Date: _____/______/_____ Time: __:__ am/pm. Location:______________________________
If not scheduled, Indicate Reason & Recommendation: ____
____
____
Reviewing Provider's Signature: ______________________________________ ID Number: _________________
Contact Number: __ __ __-__ __ __-__ __ __ __ Rev 02/19/09