Date: ____

Dear Dr. _____________________________________:

Your patient ____ is scheduled to have a:

MICRODISCECTOMY LAMINECTOMY DECOMPRESSION

FIXATION/FUSION OTHER: ______________________________

Anesthesia requires that we get a preoperative evaluation for medical clearance.

Thank you for completing the attached PREOPERATIVE CLEARANCE FORM.

If you have any questions or concerns, please do not hesitate to contact me.

Please fax the completed for to me at 804-288-4538.

Thank you for your assistance.

Sincerely,

E. Claiborne Irby, Jr., M.D.

Preoperative History and Physical

Patient's name: ____DOB__________

Date: ________________ Date of Surgery: ____________________________

Height: _____ Weight: _________ **ANY** Allergies: _____________________________

Anticipated procedure: ____

Past Medical History: ____

____

Past Surgical History: ____

____

Family History: ____

____

Social History: ____

____

Review of Systems: ____

____

Examination:

General Appearance: ____

____

HEENT: ____

____

Respiratory: ____

____

Cardiovascular: ____

____

Abdomen/Gastrointestinal:____

Musculoskeletal: ____

____

Neuro/Psyche:____

____.

Other: ____

Medications:

____

____

____

____

Impression:

SURGERY RECOMMENDED______   **SURGERY NOT RECOMMENDED____**

SIGNATURE/DATE: ____

Please stamp or print name: ____