Montefiore

PRE-OPERATIVE MEDICAL ASSESSMENT REQUEST

Patient Information Label

To provide an accurate Pre-Operative Medical Assessment in a timely manner, we ask that this form be completed by the Primary Care Physician (PCP) for any patient being referred to Montefiore Pre-Operative Evaluation Service, whose PCP does not enter their records into the Montefiore EMR system. **Please instruct the patient to bring the completed form to the pre-op assessment visit.**

To be completed by Surgeon's Office

Date: _____

Procedure:_____

Patient Name:_____

Procedure Scheduled Date:_____

Patient DOB:_____

Surgeon: _____

Montefiore MRN:_____

To be completed by PCP

PCP Name: _____   Phone/Pager:_____

Address: _____   Patient Last seen:_____

Past Medical History (check all that applies):

☐ CAD: ☐ PCI ☐ CABG_____

☐ CVA: _____

☐ CHF: _____

☐ Valve Disease: _____

☐ Arrhythmia:_____

☐ DM: (A1c:) _____

☐ HTN: _____

☐ Asthma/COPD: _____

☐ Pulmonary Hypertension: _____

☐ Periph Vascular DZ: _____

☐ CKD: (baseline Cr/GFR:) _____

☐ OSA: _____

☐ Other PMH: _____

_____

_____

_____

Allergy/Adverse Reactions:

_____

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Medications:

☐ See attached – Reviewed and Confirmed by PCP

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Please include the following reports, if available:

☐ Cardiac Stress Test

☐ Echocardiogram

☐ Cardiac Cath/PCI

☐ Sleep Study

☐ Pulmonary Function Test

_____

_____

_____

_____

PCP PRINT NAME_____ SIGNATURE/CREDENTIALS_____ DATE/TIME _____