THE ORTHOPAEDIC FOOT & ANKLE CENTER

A Division of The Centers for Advanced Orthopaedics

Surgical Clearance Requirements

Dear Doctor:

Your patient has been scheduled for foot/ankle surgery. A medical clearance is required by all facilities to ensure a safe outcome. Please fax complete clearance to our office at **703-560-2151.**

- History and Physical Exam and Labs are valid for 30 days.
- EKG's that are normal are valid for 90 days.

ALL PATIENTS require at minimum the following:

1. History & Physical Exam, form attached

Patients who are **50 years and older or who have diabetes, hypertension or a BMI greater than 35 requires the following:**

1. History & Physical Exam Form (attached)
2. EKG
3. CBC
4. CMP

Patients with **Cardiac Disease (excluding HTN) require the following:**

1. H/P form (attached)
2. EKG
3. CBC
4. CMP
5. Cardiac clearance

These tests meet the minimum requirements for surgical clearance; further testing is at your discretion.

Please note patients with a BMI greater than 40 may be required to have an airway evaluation prior to surgery

2922 Telestar Court, Falls Church,Va. 22042
TEL: 703-584-2040 FAX: 703-560-2151

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History & Physical Form- Completed by a Physician
FAX TO: 703-560-2151

Patient Name: _____DOB:_____ Age: _____

Type of Surgery: _____

Hospital: _____

History of Present Illness:

_____

PAST MEDICAL AND ALLERGIC HISTORY:
CURRENT MEDICATIONS:
ALLERGIES & DRUG REACTIONS:
HISTORY OF BLEEDING TENDENCIES/CLOTTING DISORDERS:
RELEVANT FAMILY HISTORY:
PAST MEDICAL HISTORY:
PAST SURGICAL HISTORY
HOSPITALIZATIONS:
LATEX:
IMMUNIZATIONS (INCLUDING LAST TETANUS):
PRIOR ANESTHESIA HISTORY (REACTIONS):
ENVIRONMENT AND SOCIAL
MARITAL STATUS: □ S □ M □ D □ W EDUCATION:
OCCUPATION:
SMOKING: CURRENT PAST SECONDARY
ALCOHOL USE: CURRENT PAST
DRUG USE: CURRENT PAST
FAMILY HISTORY
PARENTS
SIBLINGS
OTHER

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Patient Name: _____DOB:_____
REVIEW OF SYSTEMS:

Vital Signs: PULSE: TEMP: BP: / RR: HT: WT: BMI:

Physical Exam	**Normal**	**Abnormal**	**Abnormal Findings**
HEENT	☐	☐	
LYMPH	☐	☐	
CARDIOVASCULAR	☐	☐	
RESPIRATORY	☐	☐	
GASTROINTESTINAL	☐	☐	
GENITOURINARY	☐	☐	
MUSCULOSKELETAL	☐	☐	
INTEGUMENTARY	☐	☐	
NEUROLOGIC	☐	☐	

LAB AND EKG REPORTS (PLEASE ATTACH)
ASSESSMENT:
RECOMMENDATIONS FOR PERI-OPERATIVE CARE:
CLEARED FOR SURGERY: ☐ YES ☐ NO
NOTES OR COMMENTS:

SIGNATURE: _____DATE: _____

PRINTED NAME: _____TELEPHONE: _____

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