

**Columbia University Medical Center
ColumbiaDoctors Ophthalmology
635 West 165th Street, Flanzer Suite
New York, NY 10032
Fax: (212) 342-5435 Telephone: (212) 305-3069**

Pre-Surgical Medical Clearance with your Medical Doctor

Patient Name: _____ Surgery Date: _____

Procedure: _____ Doctor: _____

- A letter of medical history and clearance for surgery (see attached) and the results of the following laboratory tests are required before proceeding with your surgery.

- The lab results needed are as follows:
 - **Basic Metabolic Profile**
 - **Complete Blood Count**
 - **PT/PTT**
 - **Electrocardiogram (EKG) done within the past 1 year**

These results must be dated within thirty (30) days of the date of surgery. All of the above must be faxed to the Surgical Scheduling Office at least **4 days** prior to the date of surgery.

Our fax number is (212) 342-5435 and our phone number is (212) 305-3069.

Please note that we require your clearance in a timely manner.

Length of Procedure: _____

Type of Anesthesia: _____



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**PERIOPERATIVE SERVICES / HISTORY & PHYSICAL
 DAY OF SURGERY ORDERS**

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Date: _____ Time: _____ AM/PM

SUBMIT THIS DOCUMENTATION AND ALL TEST RESULTS TO THE PRESURGICAL DOCUMENTATION CENTER NO LATER THAN 2 DAYS PRIOR TO THE DATE OF SURGERY

PATIENT NAME:		ADMISSION DIAGNOSIS: (1)	
HISTORY NUMBER: (UNCONFIRMED)	AGE:	DOB:	SECONDARY DIAGNOSIS: (2)
FATHER'S FULL NAME:		PROCEDURE/OPERATION:	
REFERRING PHYSICIAN NAME:		PROCEDURE DATE: _____/_____/_____	CONFIRMATION #:
GOING TO PAT <input type="checkbox"/> YES <input type="checkbox"/> NO	PREADMISSION TESTING DATE: _____/_____/_____	PAT AT NYPH? <input type="checkbox"/> YES <input type="checkbox"/> NO Where _____	PRINT SURGEON NAME/ID CODE:

HISTORY AND PHYSICAL

HISTORY OF PRESENT ILLNESS (HPI):
 Specific Surgical in PI: Narrative HPI

HISTORY:

Past Surgical History:

Surgery	Date
	/ /
	/ /
	/ /
	/ /

Past Medical History:

Condition	Date
	/ /
	/ /
	/ /
	/ /

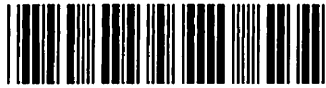
Medications: List of Medications (including over -the-counter medications): (Complete Medication Reconciliation form - 51187)

Medications	Dosage	Frequency

Family History: Heart Attack Cancer Colon Problems Other _____ None

Do you have allergies? Yes No FOOD DRUG LATEX OTHER _____	
ALLERGEN	REACTION

50173 (9/11)



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REVIEW OF SYSTEMS:

	Normal	Abnormal	Describe Abnormal findings
Constitution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fever <input type="checkbox"/> Weight loss <input type="checkbox"/> Other _____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Heart attack <input type="checkbox"/> Chest pain <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Hypertension <input type="checkbox"/> Claudication <input type="checkbox"/> Other _____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Cough <input type="checkbox"/> SOB <input type="checkbox"/> Other _____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> GERD <input type="checkbox"/> Peptic Ulcer disease <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Irritable bowel <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hypercholesteremia <input type="checkbox"/> Gall Bladder disease <input type="checkbox"/> Other _____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Renal Failure <input type="checkbox"/> Other _____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Other _____
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stroke <input type="checkbox"/> Other _____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Other _____
Endocrine/Metabolic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diabetes <input type="checkbox"/> Lupus <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Other _____
Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Anemia <input type="checkbox"/> Other _____
Substance Abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	substance _____ last used : ____/____/____
Smoking	<input type="checkbox"/> No	<input type="checkbox"/> Yes	when quit : ____/____/____ ppd: _____
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

PHYSICAL EXAM: (check all that apply)

CONSTITUTIONAL:

VS: Temp _____ °C Pulse _____ Respiration _____ BP _____ Height _____ (cm) Weight _____ (kg)

General Appearance Normal Malnourished Overweight Obese Morbidly obese

EYES

Inspection of conjunctiva, lids: Normal Icteric conjunctiva periorbital edema abnormal sclerae Other _____

Examination of pupils/Iris: PERRLA Other: _____

NECK

Overall appearance: Normal **Masses:** None Lymph nodes _____ JVD Other: _____

Thyroid: Normal Other: _____

RESPIRATORY

Effort: Normal Tachypneic Use of accessory muscles Other: _____

Lungs (Auscultation): Normal Other _____

CARDIOVASCULAR

Auscultation of Heart: Normal Murmur Other _____

Examination of Extremities: Normal Venous insufficiency Varicose veins Edema Other _____

GASTROINTESTINAL

Examination of Abdomen: Normal Masses _____ Tenderness _____

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MUSCULOSKELETAL:

Examination of Gait and Station: Normal Abnormal _____
Assessment of Strength and Tone: Normal Atrophy _____ Tremor _____ Other _____

SKIN

Inspection: Normal Erythema Stasis dermatitis Jaundice Ulcer _____
 Other _____

Palpation: Normal Induration subq nodules Other _____

NEUROLOGICAL/PSYCHIATRIC

Orientation: Normal Other _____
Mood: Normal Other _____

DIAGNOSIS:

PLAN FOR SURGERY:

INFECTION PRIOR TO ANESTHESIA/PRINCIPAL PROCEDURE/SURGERY START TIME

- Yes, Preoperative Infection exists
- Yes, Suspected / Possible Preoperative Infection exists
- No

JUSTIFICATION / REASON FOR VANCOMYCIN USE: (check all that apply)

- Beta-lactam (penicillin or cephalosporin) allergy
- MRSA colonization or infection
- High-risk due to acute inpatient hospitalization within the last year
- Chronic wound care or dialysis
- High-risk due to nursing home or extended care facility setting within the last year, prior to admission
- Increase MRSA rate, either facility-wide or operation-specific
- Inpatient stay more than 24 hours prior to the principal procedure
- Undergoing valve surgery
- Transferred from another inpatient hospitalization after a 3-day stay
- Not Applicable

Signature: _____ MD/PA/NP Date: ____/____/____ Time: _____ AM/PM

Print Name: _____ ID CODE # _____

Reviewed by Attending Surgeon: _____ MD Date: ____/____/____ Time: _____ AM/PM

Print Name: _____ ID CODE # _____