Rocky Mountain Scoliosis & Spine; 1721 E. 19th Ave.; Suite 244; Denver, CO 80218;
PHONE (303) 301-9006 / FAX (303) 861-4741

REQUEST FOR WRITTEN MEDICAL CLEARANCE

DEAR DOCTOR:_____.

RE: _____.

Attached is a one page medical clearance form for your patient, who is scheduled for spine surgery by Dr. Shay Bess

Please fill out the attached form, or, send us a written note regarding this patient's medical history and clearance status. This form will be forwarded to the assigned hospital's Pre-anesthesia Dept. to assist with anesthesia clearance. **If your patient is age 40 or older, an EKG performed within 6 months of the scheduled day of surgery is required by the Hospital Anesthesia staff.** Please forward your EKG report, and any other test reports you feel are needed in order to provide this medical clearance, to us to prevent unnecessary duplication of services. This patient will be scheduled at this office for his or her preoperative office visit on the following date: _____. We appreciate receiving this information before this date, if at all possible.

Your patient will also attend a pre-admission visit on or near the date at the hospital listed below. Any tests not performed by you, which are still required for surgical admission, will be performed at this time. ***If the patient's insurance requires that you perform all testing, the following are considered standard for surgery preparation: CBC, Chemistry Panel, PT/PTT, UA, CXR and EKG. **A type and screen, or type and crossmatch must be performed at the hospital where surgery is scheduled to verify the compatibility of donated blood.**

Please fax the attached completed form, EKG report and any other test reports you have performed to complete this clearance to 303-861-4741; ATTENTION: Tiffany or Breton.

Thank you for assisting us in preparing your patient for surgery. We will update you whenever we can with progress notes. Please don't hesitate to call if you have any questions.

Sincerely,

Shay Bess, MD

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PATIENT NAME:_____.

SSN: _____.

DOB: _____.

Is in the process of being prepared for spine surgery.

HOSPITAL: _____.

SURGERY DATE: _____.

PROCEDURE: _____

_____

APPROXIMATE LENGTH OF ANESTHESIA: _____ HOURS

In addition to performing an overall medical clearance for general anesthesia, we would appreciate your evaluation of any specific medical problems.

MEDICAL EXAMINATION

WT._____ HT. _____ BP _____ PULSE _____ (REG. / IRREG.) RESP. _____ TEMP. _____ (ORAL)

GENERAL APPEARANCE: Normal ____ Obese ____ Morbidly Obese ___ Debilitated _____

LUNGS: _____

HEART : _____

EKG RESULTS:_____

ADDITIONAL COMMENTS: _____

_____

_____

_____

MY PATIENT IS MEDICAL CLEARED FOR SURGERY: YES _____ NO _____

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME (print): _____ PHONE: _____