



To: _____ From: _____

Patient: _____

Surgery Date: _____ Hospital: _____

Type of Surgery: _____

Please perform the following PRE-ADMISSION TESTING to fulfill ANESTHESIA REQUIREMENTS

- ☐ Complete History and Physical: Within 30 days of surgery. EACH page must state date of service, patient's name, DOB and physicians signature.
- ☐ EKG: Must state patients name, DOB, and physicians signature and date of service on EKG interpretation.
 - **12 Months:** History of high blood pressure, Weight >300lbs/ BMI >39, Diabetes, Cardiovascular disease, sleep apnea with use of CPAP machine.
 - **60 Days:** New heart disease or stents
- ☐ Cardiac Clearance: Within 12 months for stable risk factors. Within 30 days of surgery for any cardiac event within the last year (ie: chest pain, new atrial fibrillation or other arrhythmia, Heart Failure, cardiac surgery, or angioplasty). ECHO within 24 months for a patient with asymptomatic aortic stenosis, pulmonary hypertension, heart failure.
- ☐ Chest X-Ray: Acute moderate or severe COPD or Acute CHF
- ☐ ECHO within 24 months for a patient with asymptomatic aortic stenosis, pulmonary hypertension, heart failure.

Bloodwork within 60 days of surgery

- | | |
|--|---|
| <input type="checkbox"/> Amylase & Lipase | <input type="checkbox"/> CMP |
| <input type="checkbox"/> CBC with Platelet | <input type="checkbox"/> Hemoglobin A1C (all Diabetics) |
| <input type="checkbox"/> PT/PTT (Within 17 days) | <input type="checkbox"/> Serum HCG (Within 7 Days) |
| <input type="checkbox"/> Urinalysis | <input type="checkbox"/> Sodium and Potassium (Within 24 hours) |
| <input type="checkbox"/> BMP | <input type="checkbox"/> Urine Culture with Sensitivities |

PLEASE FAX ALL PRE-ADMISSION TESTING BY _____

ALL INFORMATION MUST BE IN THE HOSPITAL COMPUTER SYSTEM 72 HOURS PRIOR TO SURGERY.