Star Physician Partners

TELEPHONE ENCOUNTER

PATIENT NAME:	DATE: 2005
CALLER'S NAME:	TIME: AM / PM
DATE OF BIRTH:	FAX NUMBER:
PHONE NUMBER:	PROVIDER:
ALTERNATE PHONE NUMBER:	HOESCH COOL SPEIGHT
MESSAGE TAKEN BY:	MUCHA BLUME

MESSAGE:

PHARMACY NAME:	PHARMACY PHONE NUMBER:
ALLERGIES / OTHER PERTINENT INFORMATION:	

MedStar Physician Partners

TELEPHONE ENCOUNTER

PATIENT NAME:	DATE:
CALLER'S NAME:	TIME: AM / PM VM
DATE OF BIRTH:	FAX NUMBER:
PHONE NUMBER:	PROVIDER:
ALTERNATE PHONE NUMBER:	COOL SPEIGHT MUCHA
MESSAGE TAKEN BY:	BLUME KATS

MESSAGE:

PHARMACY NAME:	PHARMACY PHONE NUMBER:
ALLERGIES / OTHER PERTINENT INFORMATION:	

V4
V5
V6
V1
V2
V3
aVR
aVL
aVF
II

SURGERY CENTER

M.D., F.A.C.S.
, M.D.

PRESURGICAL MEDICAL EVALUATION

To: _____ _____
Name of Physician — Today's Date

_____ will have:
Name of Patient

_____ _____
Type of Surgery — Surgery Date

Surgery will be performed at:
- ☐ Our ambulatory surgical facility,
- ☐ Hospital _____

Anesthesia will be:
- ☐ Local / IV sedation anesthesia
- ☐ General anesthesia

☐ **Please note:**

☐ Presurgical evaluation and perioperative management is requested for the following diagnosis.

1) V72.84 (Pre-surgical clearance) 2) _____

3) _____ 4) _____

☐ **Kindly arrange for the following tests 2 to 3 weeks prior to the scheduled surgery date:**

☐ HISTORY & PHYSICAL EXAM	☐ CMP	☐ PT, APTT, INR
☐ CBC	☐ Magnesium	☐ HCG
☐ EKG	☐ Phosphorous	☐ HIV
☐ Chest X-Ray	☐ Mammogram	☐ EMG & NCS

☐ Auto-transfusion for _____ units

☐ Please obtain written consent for HIV Screen

☐ **Please send reports to:**
- ☐ Hospital admitting office
- ☐ Our Facility