

Preoperative Evaluation Check-off List

Name of Patient :

Name of UFM physician:

Date of Procedure:

Name of Surgeon:

Place where surgery will be done if other than surgery center:

Information requested of UFM physician	Check if attached	Rec'd by PSC
H + P	_____	_____
EKG	_____	_____
Labs	_____	_____
Check off which one:		
AIP	_____	
Quest	_____	
LabCorp	_____	
Other	_____	
X ray	_____	_____
Other (write in)	_____	_____

*please place chart, with above material in referral basket on each station
 No copying of records, nor faxing of the above information necessary

If any questions; please speak with:

8-3345