Medical CONSULTANTS

Patient Focused • Quality Oriented • Physician Driven

Pre-Operative Cardiovascular/Surgical Risk Assessment Referral

Referring Surgeon _____

Referring Surgeon phone # _____ Fax #_____

Do you want called after appt.?_____

Patient name_____ Date of Birth_____

Diagnosis: _____

Type of Surgery: _____

Type of Anesthesia: _____

Anticipated length of surgery: _____

Appointment urgency: ☐ within 1 week ☐ within 1 month

Referring Surgeon Signature_____

Is patient currently on **antiplatelet** agent? _____ Is patient currently on **anticoagulant**? _____

Special communication needs for patient? _____

PLEASE FAX MEDICAL RECORDS TO: 765-281-2150

____ Recent office note/H&P

____ Recent Cardiology testing (Echo, Nuclear Stress test, EKG, etc.)

____ Recent Peripheral Vascular testing (Arterial Doppler, CTA, etc.)

____ Has the patient recently been hospitalized? Which facility?_____

____ Updated medication list ____ Labs results

____ Patient's insurance cards

MEDICAID	ID#
MEDICARE	ID#
COMMERCIAL (TYPE)	GROUP# ID#
SELF PAY	