Print Form

Samaritan
Medical Center
Watertown, NY

Place patient identification sticker here

PREOPERATIVE MEDICAL CONSULTATION / OPTIMIZATION

NAME: _____ DOB: _____ AGE: _____

PROPOSED SURGERY: _____

ALLERGIES: ☐ NKA _____

MEDICATIONS: Please provide a list of current medications.

Is the patient currently on, or have they historically taken any of the following classes of drugs (please provide details including drug names, date and dosage)?

Anticoagulants:	☐ Yes ☐ No _____	Illicit drugs:	☐ Yes ☐ No _____
Weight reduction drugs:	☐ Yes ☐ No _____	Steroids:	☐ Yes ☐ No _____
Chemotherapy:	☐ Yes ☐ No _____	Smoking / Alcohol:	☐ Yes ☐ No _____

MEDICAL HISTORY / REVIEW OF SYSTEMS: (please provide details including dates of illness and recent studies):

Lung Disease:	☐ Yes ☐ No	_____
Hypertension:	☐ Yes ☐ No	_____
Heart Disease:	☐ Yes ☐ No	_____
Vascular Disease:	☐ Yes ☐ No	_____
Diabetes:	☐ Yes ☐ No	_____
Kidney Disease:	☐ Yes ☐ No	_____
Neurologic Disease:	☐ Yes ☐ No	_____
Musculoskeletal Disease:	☐ Yes ☐ No	_____
Gastrointestinal Disease:	☐ Yes ☐ No	_____
Liver Disease:	☐ Yes ☐ No	_____
Bleeding Disorder:	☐ Yes ☐ No	_____
Thyroid Disease:	☐ Yes ☐ No	_____
Other Disease:	☐ Yes ☐ No	_____
Surgical History:	☐ Yes ☐ No	_____
		_____
		_____

PHYSICAL EXAM: BP _____ P _____ R _____ T _____ HEIGHT _____ WEIGHT _____

General: _____

Mental Status: _____

HEENT: _____

Neck: _____

Lungs: _____

Heart: _____

Abdomen: _____

Extremities: _____

Neurologic: _____

Other (including breast/pelvic/rectal exam, if completed): _____

_____

_____

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NAME: _____ DOB: _____ AGE: _____

LAB/STUDIES (if indicated)	DATE	RESULT	If prior study is available, are there any significant changes (give details)?
CXR			☐ Yes ☐ No _____
EKG			☐ Yes ☐ No _____
Cardiac Echo			☐ Yes ☐ No _____
Stress Test			☐ Yes ☐ No _____
PFT'S			☐ Yes ☐ No _____
CBC			☐ Yes ☐ No _____
CHEMISTRY			☐ Yes ☐ No _____
PT/PTT/INR			☐ Yes ☐ No _____
OTHER			☐ Yes ☐ No _____

Please send copies of any labs/studies above that were not performed at Samaritan Medical Center.

ASSESSMENT/PLAN:

- Is the patient at higher than average risk for perioperative complications? ☐ Yes ☐ No

  Please explain: _____

- Are the patient's acute and chronic medical conditions fully optimized at the present time? ☐ Yes ☐ No

  Please explain: _____

- Are there any readily alterable factors that could lower the patient's perioperative risk? ☐ Yes ☐ No

  Please explain: _____

- Any other specific perioperative recommendations (please include schedule for stopping any current medications):

(Please attach further sheets as needed)

Printed/stamped Name & Title (MD, DO, NP, PA) _____ Signature _____ Date _____ Time _____

Please fax completed paperwork to (315)405-4583

Thank you!