Patrick C. McCulloch, M.D.
Laura Fertak, PA-C Erin Placette, PA-C
Houston Methodist Orthopedics & Sports Medicine
O: 713.441.3667
F: 713.790.2058

Surgical Clearance

Patient's Name: ____

DOB: ____________________________________

MRN: ____________________________________

Diagnosis: ____

Procedure:____
____
____

Clearances required:

◯PCP	◯Endocrinology	◯_______________
◯Cardiology	◯Pain Management	◯_______________
◯Pulmonology	◯_______________	

By signing this, you attest that the patient may proceed with the procedure listed above. Please fax this signed form along with last clinical note, recent labs results, and diagnostic studies to **713.790.2058.** Surgery cannot be scheduled until all information is received. Thank you!

Physician's Name: ____

Specialty: ____

Signature: ____

Date Signed: ____

Recommendations for perioperative anticoagulant management:
(May leave blank if patient is currently NOT prescribed or taking anticoagulant)
____
____

Surgical clearances must be within 6 months from date of surgery.

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Additional Comments:
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