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 for Total Shoulder/Reverse Total Shoulder

Patient's Name: _____

DOB: _____

MRN: _____

Diagnosis: R L Shoulder Osteoarthritis Rotator Cuff Tear

Rotator Cuff Arthropathy Proximal Humerus Fracture

Other: _____

Procedure: R L Total Shoulder Arthroplasty Reverse Total Shoulder Arthroplasty

Clearances required:

◯PCP ◯Endocrinology ◯_____

◯Cardiology ◯Pain Management ◯_____

◯Pulmonology ◯_____

History of Metal Allergy: Yes No **History of MRSA**: Yes No

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: _____

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

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

_____

_____

Additional Comments:

_____

_____

_____

_____

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