Indianapolis Perioperative Medicine, LLC

Peter Caccavallo, M.D.
Internal Medicine
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PLEASE READ ALL PAGES IMMEDIATELY. YOU MAY NEED MORE THAN ONE DAY TO COMPLETE.

We have been asked by your surgeon to perform a medical consultation with you before you undergo your planned surgery. The purpose of this consultation is to identify all of your medical or non-surgical conditions that will need to be appropriately managed until you are discharged from the hospital.

Studies have shown a significant improvement in outcomes of patients who undergo this type of evaluation versus those who do not. All surgical procedures have certain inherent risks. Our goal is to lessen these risks by evaluating and treating any underlying medical illness both before and after surgery.

Your assessment will consist of a detailed medical history followed by a physical examination, EKG, blood work and possible breathing tests and chest x-ray if indicated. Depending on the results of your history and physical, further studies may be necessary in order to obtain medical clearance for surgery.

We look forward to meeting you and having the privilege of caring for you around the time of your surgery. If you have any questions or concerns regarding your preoperative assessment, please do not hesitate to contact our office.

Sincerely yours,

Indianapolis Perioperative Medicine, LLC

Please complete the attached forms. You must bring them with you to your preoperative assessment -Please fill out all of the attached paperwork **before** your appointment. The information obtained during this assessment is essential for planning your procedure, anesthesia, and to ensure the safest possible surgery.

Bring ALL of the bottles of your medications and supplements you are currently taking (not only a list), so that we can confirm your exact regimen.

Expect your appointment to last up to 1-2 hours.

Detach and give the page titled *******Request for Medical Records******* to any doctor that may have the medical records requested.** This is usually your primary care provider and cardiologist (if applicable). Please fill in your name, birth date, phone number, and signature. You may photocopy the request and send it to each doctor. **PLEASE VERIFY WE HAVE RECEIVED THE RECORDS PRIOR TO YOUR APPOINTMENT BY CALLING (317) 338-9424. If records are not received YOU WILL BE RESCHEDULED WHICH COULD CAUSE YOUR SURGERY TO BE DELAYED.**

Copayments are due at the time of the appointment. We only accept cash or check.

PATIENT INFORMATION

Patient Name: _____DOB_____ Phone: _____

Social Security Number: _____ Surgery date: _____

Primary Care Doctor's Name: _____

Address: _____

_____

Phone Number: ___(_____)_____

Fax Number: ___(_____)_____

Please list the Name and Numbers of other doctor's responsible for your medical care:

Name of Physician	Medical Problem(s) Managed	Phone number/Fax

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*****REQUEST FOR MEDICAL RECORDS*****

Please email the following information to Indianapolis Perioperative Medicine. (You may fax or mail if email not available.)

Patient Name: _____DOB_____

Patient's Phone: _____

I authorize any holder of medical or other information about me to be released to Indianapolis Perioperative Medicine, LLC. The information will be used to assist in the preoperative assessment.

_____ _____
Patient's Signature Date

Old records requested – Please send ONLY the most RECENT of the following below. (Excessive records are not needed and may result in a charge from your physicians.)

- **Echocardiogram** – *if done in last 2 years*
- **Stress test or cardiac catheterization report** – *if done in last 2 years*
- **Cardiology office note** – *most recent note only*
- **Hemoglobin, creatinine, and A1c** – *most recent only*
- **EKG** – *most recent only*
- **CXR** – *if done in last 6 months*