MID-STATE HEALTH CENTER

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Primary Care Medicine • Behavioral Health • Dental Care

midstatehealth.org

Mid-State Health Center
Fax # 536-4001

Pre-op Medical Consultation Request for Mid-State Health Center

Patient Name: _____ Date of Birth: _____

Date of Request: _____

Referring Physician: _____
(Print Name)

Referring Physician NPI #_____

Referring Physician Organization & Department: _____

Referring Physician Best Contact Number: (_____)_____

Patient's Mid-State PCP:_____

Procedure Planned: _____

Date of Procedure: _____

Type of Anesthesia to Be Used: ☐ Mac ☐ Topical ☐ Local ☐ Nerve Block ☐ General

☐ **Labs** (☐ **Required** **OR** ☐ **At Clinician Discretion**)

☐ **CMP** ☐ **BMP** ☐ **CBC** ☐ **HgbA1c** ☐ **UA**

☐ **Other: _____**

☐ **EKG** *(Not recommended for cataract surgery)*

☐ **Required** ☐ **At Clinician Discretion**

Conditions to be optimized for surgery: (Check appropriate boxes)

☐	Heart Disease	☐	COPD	☐	Diabetes
☐	Atrial fib	☐	HTN	☐	Asthma
☐	Multiple Meds	☐	Anti-coagulation		
☐	Other_____				

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