Mid-State Health Center
Fax # 536-4001

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

Patient Name: **[Patient->Full Name]** Date of Birth: **[Patient->Date Of Birth]**

Date of Request: **[Default->Today's Date]**

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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