

Fax - Four Peaks Surgery Center

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**To:** Dr. drName

**Fax to:** fNumber

**Patient**: ptName

**DOB**: dateOfBirth

**Surgery Date**: procedureDate

**Type of Surgery: procedureName**

**Please fax the following**: (XX)

**A PreOp Clearance Note from Your Physician: \_\_\_xx\_\_\_\_**

**EKG (Within 90 days of surgery): \_\_\_xx\_\_\_\_**

**Pacemaker/ Defibrillation Form to be completed: \_\_\_\_\_\_\_**

Chest X-Ray (Within the last year): ­­­­\_\_\_\_\_\_\_

Labs (Within 90 days of Surgery) CBC, BMP, PT, PTT,

**PLEASE ADVISE AND NOTE ON PREOP CLEARANCE WHEN PT SHOULD STOP TAKING BLOOD THINNER/S.**

**TO AVOID POSSIBLE SURGERY CANCELLATION, PLEASE FAX PRE OP CLEARANCE 1 WEEK PRIOR TO SURGERY.**

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