Surgi Core
SURGICAL CENTERS

Patient Name: txt_name|patientfullname
DOB: txt_dob|DOB
Scheduled
Procedure: _____

I, the undersigned, confirm the following:

1. I am aware that due to COVID-19, an Executive Order has been issued requiring hospitals and ambulatory surgery centers cancel or postpone elective procedures.
2. I have evaluated the above-referenced patient and have determined that, in my professional judgement, the risk to the patient that would result from postponing or cancelling this procedure is such that the proposed procedures is not elective.
3. State the medical reason as to why this procedure is **not elective** below:

_____
_____
_____
_____
_____
_____

Physician signature: _____

Print Name: Anjani Sinha, M.D.

Date: txt_date|ToDay