MUNSON HEALTHCARE

Form #11063 (10/18)

POAC CONSULTATION REFERRAL

Patient Name:_____ **DOB:**_____ **Phone:**_____

Consulting Physician:_____

Primary Care Provider:_____

Procedure:_____ **Date of Procedure:**_____

Diagnosis:_____ **Clinically Urgent:** ❑ Yes ❑ No

TYPE OF ANESTHESIA: _____

PRIMARY CONCERNS:_____

_____

MEDICAL HISTORY (please check all that apply):

- ❑ **Diabetes**
  Endocrinologist/location_____
- ❑ **Asthma/COPD**
  Pulmonologist/location_____
- ❑ **CV Disease**
  Cardiologist/location_____
- ❑ **Chronic kidney disease**
  Nephrologist/location_____
- ❑ **CVA**

❑ **Anticoagulation**

❑ **Surgeon would prefer patient to <u>remain</u> on anticoagulation or antiplatelet therapy for surgery.**

❑ **Surgeon would prefer patient to <u>stop</u> anticoagulation or antiplatelet therapy _____ days prior to surgery.**

Please complete this form and fax to the **Pre-operative Assessment Clinic @ 231-935-2687**. Please Include a copy of last office notes, recent labs, EKG's, echo and/or stress tests, and medication lists. Please call 231-935-2686 for scheduling assistance, and any other pertinent medical records when available.

Thank you,

The Pre-operative Assessment Clinic