ClearCare MEDICAL

Specializing in Pre-Op Clearances
& Medical / Legal Consultative Services

Pre-Operative Clearance Request Form

Patient Information:	Attorney Information:
Name:	Attorney Name:
Date of Birth:	Law Firm:
Phone Number:	Phone Number:
Address:	Fax Number:
Email Address:	Email Address:
Date of Accident:	Case Manager:

Surgery Information:

Date of Surgery:	
Surgical Procedures:	
Type of Anesthesia:	
Surgery Center:	

Please indicate which tests need to be included for pre-op clearance:

- ☐ CBC
- ☐ Urinalysis
- ☐ EKG
- ☐ Beta HCG Quantitative
- ☐ CMP
- ☐ PT & PTT
- ☐ Chest X-Ray
- ☐ Other: _____

Referral Source Information:

Name:	Fax Number:
Phone Number:	Contact Person:
Contact Email Address:	Surgeon Name: