

## PRE SURGICAL TESTING REQUIREMENTS

### HISTORY AND PHYSICAL

All Patients Within 30 days of surgery

---

### EKG

Any patient with Diabetes, Hypertension, Cardiac, Vascular, Pulmonary, Renal, or Hepatic Disease

All Men > 45 years old

All Women > 55 years old

Within 3 months of surgery

---

### CHEST X-RAY

Not required

### LABORATORY WORK

Within 30 days of surgery

	<u>General Anesthesia</u>	<u>MAC</u>	<u>Anterior Segment Surgery under MAC only</u>
Healthy Patient	none	none	none
Diabetes Hypertension Cardiac/Pulmonary Renal	BMP	BMP	none
Liver disease	CBC, BMP PT/PTT, LFT	CBC, BMP PT/PTT	none
Coumadin therapy	INR	INR	none

For history of anemia or for surgeries where blood loss is expected to be >200cc, please include CBC

For patients on kidney dialysis, K+ should be obtained day of surgery

All diabetic patients glucose levels (i.e. finger stick) to be checked day of surgery

Urine pregnancy day of admission for all women of menstruating age

For patients with AICDs, please see NYEE's policy concerning defibrillators

**Patients with more complex medical conditions may require further workup (i.e stress tests, echocardiogram, cardio/pulmonary consult, etc). Please consult anesthesia department or patient's PMD.**

Cataract Surgery under MAC does not require an EKG if there are no coexisting diseases, regardless of age.

CBC = complete blood count, BMP = basic metabolic profile, LFT = liver ftinction test, K+ = potassium

PT/PTT/INR = prothrombin time/partial prothrombin time/international normalized ratio

AICD = internal cardiac defibrillator



310 East 14th Street  
New York, NY 10003-4297

**AMBULATORY SURGERY  
PRE-OPERATIVE MEDICAL EVALUATION**

Continuum Health Partners, Inc.

Tel: (212) 979-4306 Fax: (866) 333-0174

# Web Form



Surgical Procedure

Patient Name: \_\_\_\_\_

Surgery  
Date

Anesthesia  
Type

Date of Birth: \_\_\_\_\_

Surgeon

CONDITION	HISTORY?		STABLE?		INDICATE CONDITION NUMBER (#) AND COMMENT BELOW REGARDING MEDICAL CONDITION TYPE AND DURATION
	NO	YES▶	YES	NO	
① Coronary Artery Disease					If Myocardial Infarction, indicate type and year(s):
② Hypertension					
③ Congestive Heart Failure					
④ Cardiac Arrhythmia					
⑤ Valvular Heart Disease					
⑥ Pulmonary Disease					
⑦ Diabetes Mellitus					
⑧ Bleeding Diathesis					
⑨ Renal Disease					
⑩ Hepatic Disease					
⑪ Other Medical Condition(s)					

Surgical History

Medication Allergy / Sensitivity

Medication Allergy / Sensitivity

Last Menses (If Applicable)	Tobacco Use	ETOH Use	Drug Use
--------------------------------	----------------	-------------	-------------

**Y**

**MEDICATIONS**

**D**

**O**

**S**

**E**

**A**

**&**

**S**

**T**

**I**

**O**

**N**

**S**

P H Y S I C A L	B.P.	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
	HEART			
PULSE	LUNGS			
OTHER PERTINENT FINDINGS:				

**D**

**A**

**T**

**A**

**LABORATORY, EKG, and X-Ray Evaluation ▶ See reverse side of this form for minimum requirements. Supply other pertinent results and information as deemed necessary. Send reports and mounted interpreted EKG's with this form. Please comment here on abnormal results.**

**C**

**L**

**E**

Do you wish to make any peri-operative management recommendations?  No  Yes

**A**

**R**

**A**

**N**

**C**

**E**

**STATEMENT OF CLEARANCE: "There are no medical contraindications for the proposed procedure."**

Examiner's Name (Printed)	License #	Date
Examiner's Address	Telephone #	
Examiner's Signature	REVIEWED (Surgeon's Signature) BY:	Date