Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

PRE-SURGICAL Clearance Request

***Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Diagnosis:_____

DX CODES: ***ICD-10*** : _____, _____, _____

Date of Surgery: _____/_____/_____ Physician performing the surgery: _____

Scheduled Procedure: _____

Requested Services:

- ☐ **History and Physical Exam**
- ☐ **EKG**

LABS:	**Must have been done within**
☐ CBC	30 days prior to surgery date
☐ PT, PTT	30 days prior to surgery date
☐ BMP	30 days prior to surgery date
☐ CMP	30 days prior to surgery date
☐ Urinalysis	30 days prior to surgery date
☐ Other: _____	

Comments:_____

_____

FAX CLEARANCE ATTN to:_____ **# (**_____)-_____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____ **Fax Number:** _____