


  
**Infusion Associates**
  
 3230 Eagle Park NE, Suite101
   
 Grand Rapids, MI 49525
   
 616-954-0600 Phone
   
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## PRE-SURGICAL Clearance Request

*\*\*Please fax a copy of patient's Demographics, Current Lab Results, and Medical History\*\**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Phone Number(s) \_\_\_\_\_ Allergies: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ DX Code: \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Date of Surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dr. to perform the surgery: \_\_\_\_\_

Scheduled Procedure: \_\_\_\_\_

Requested Services:	<u>Must have been done within</u>
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
EKG (12 lead strip)	6 months prior to surgery date
H & P	
Other: _____	

Enclosed are the following support/forms/copies:

Demographics      Progress notes      Labs/X-Rays      Other

Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Office contact name: \_\_\_\_\_

FAX CLEARANCE TO: # (\_\_\_\_) - \_\_\_\_\_ ATTN: \_\_\_\_\_

Printed Doctor's Name: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_