ADVANCED FOOT & ANKLE CENTER

MARIO VOLOSHIN, DPM, FACFAS.
ABFAS Board Certified in Foot Surgeon.
ABFAS Board Certified in Reconstructive Rearfoot and Ankle Surgery

LESTER N. DENNIS, DPM, FACFAS.
ABFAS Board Certified in Foot and Ankle Surgery.

Surgical Medical Clearance Form

Medical clearance is needed from your physician **before your date of surgery.**

Your primary care physician should complete the attached form.

Please print a copy and take it to your primary care physician's office for them to complete. We ask that you assist us in ensuring your primary care physician completes this form in a timely manner. If this form is not received at minimum 2 days prior to your surgery, it will be **CANCELLED**!

Thank you for your compliance.

Upon completion of this form, please fax to:

Attention: Medical clearance

Fax: (718) 389-5317

If you have any questions, please contact us via phone at (718) 389-4404

ADVANCED FOOT & ANKLE CENTER

Pre-op Evaluation

******LABS: CBC. CHEM-7, PT, PTT, RECENT CHEST-X-RAY AND EKG**

Patient's Name:_____ DOB:____/____/_____

Surgery Date:____/____/_____ Procedure:_____

Hospital:_____

Surgeon: Dr. Mario Voloshin / Dr. Lester Dennis

Significant past medical history:

Neurologic:_____ LABS: CBC_____

Cardiac/circulatory:_____ CHEM_____

Pulmonary:_____ COAGS_____

Renal/Hepatic:_____ Urine_____

Musculoskeletal:_____ Other:_____

GI:_____

Other:_____

List of previous operations:_____

_____

Current medication with doses: Drug and Food Allergies:

_____ _____

_____ _____

_____ _____

_____

B/P:_____ Pulse:_____

EKG Results:_____ Date:_____

CXR Results:_____ Date:_____

HEENT:_____

LUNGS:_____

CARD/VASC:_____

ABD:_____

EXT:_____

NEURO/PSYCH:_____

DIAGNOSIS:_____

Preoperative Recommendations:_____

Is the patient cleared to have surgery?:_____

Date:___/___/____ Print Name: _____ Signature:_____

*******************PLEASE FAX RESULTS AND FORM TO (718)389-5317**********************

165 Nassau Avenue Brooklyn, N.Y.,11222
Tel: (718) 389-4404 Fax: (718) 389-5317