

Medical Clearance for Casscells Orthopaedics

Patients Name: _____

Date of Surgery: _____

Anesthesia Type: _____

Surgery Description: _____

**This letter verifies that I have examined the above named patient on _____
(date)**

and that: (check box below)

_____ The patient is in satisfactory condition to proceed with the scheduled surgery.

_____ See the attached pertinent history and physical findings and my current recommendations for this patient.

_____ This patient is **NOT** in satisfactory physical condition to proceed with the scheduled surgery for the following reasons:

Date: _____ Doctor's Name Printed: _____

Doctor's Signature: _____

Please Check One of the Following:

_____ I would like to be consulted while the patient is in house at the hospital.

_____ I would like to be consulted only if a problem arises.

_____ I would prefer that a medical consult be done in house at Wilmington hospital by HOD or CMG (**please circle one, only if you have a preference**).

Please fax this paper to (302) 477-0902 when completed. Attn: Eileen Papp
