PRE-SURGICAL CLEARANCE

Date

Dear Colleague,

My patient, ____________________________, DOB _______________, has been evaluated by the SonoSpine Surgical Review Staff and is requesting surgical clearance.

- ❑ My patient **IS PHYSICALLY HEALTHY** to undergo outpatient spine surgery. There are currently no indications to delay surgical intervention.
- ❑ My patient **IS CLEAR to hold ALL ANTICOAGULANTS/ANTIPLATELETS AND BLOOD THINNING SUPPLEMENTS 7 -10 DAYS** prior to your planned procedure
- ❑ **PLEASE CONTACT ME DIRECTLY** to discuss the SonoSpine procedure and plan for my patient.
- ❑ My patient **IS NOT PHYSICALLY HEALTHY** to proceed with outpatient spine surgery. There are currently one or more indications to delay surgical intervention, listed below.
- ❑ Anticoagulation clearance **NOT** obtained to medical comorbidities: _________________
- ❑ Patient is physically unfit to undergo general anesthesia due to:

____
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____

I do not feel that my patient is a surgical candidate at this time. The patient will require the following time frame to complete clearance requirements.

30 Days   60 - 90 Days   Greater than 3 months   Non-Surgical

X ____________________________   X ___________________________   X ____________

Provider Name (Please print)   Provider Signature   Date

Please Fax this form with office clearance note and Lab/CXR results to: 888.274.3766