

UT Southwestern Frisco Orthopaedic Surgery

12500 Dallas Parkway, Frisco, TX 75033

Phone: 469-604-9070 Fax: 469-604-9071

Joint Replacement PCP Surgical Clearance Request

Please complete form and fax back to 469-604-9071 as your response is time sensitive

___ Standard Request (10 Business Days)

___ Urgent Request (STAT)

Patient Sticker

To: _____

From: _____

Procedure: _____ Procedure Date: _____

Pre-Procedure Requirements: Please obtain a CBC, BMP, PT/INR, UA, ECG, and chest xray. Fax those results with your last office visit note and this completed letter (see below).

Please Initial Clearance Below

___ Patient is a low risk for surgery. There are no contradictions identified to proceeding with an invasive procedure. The patient **IS** clear to proceed as scheduled.

___ Further testing is necessary to gauge the patient's risk for an invasive procedure. The patient is **NOT** yet released for the procedure.

___ The patient is at increased risk but is cleared for the procedure with the following recommendations:

1. _____

2. _____

Physician's Name (Print) _____

Physician's Signature: _____ Date: _____