



# 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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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***