Fit for Surgery Center
NavicentHealth

Pre-Procedure *Fit for Surgery* Assessment Referral Form

To: _____

Please complete the following information and fax to our office at 478-633-1947.

Appointments must be scheduled at least one week prior to surgery date.

Please include Faxed H&P if possible .

Date request submitted: _____

Patient's Name: _____ Date of Birth: _____

Patient's Contact information (Home & Cell): _____

Surgical Diagnosis: (Include ICD-10 if possible) _____

Planned Procedure: _____

Surgeon: _____ Date of Surgery: _____

Type of Anesthesia: (If known) _____

Has the patient signed Consent for surgery? (<30 days prior) O Yes O No

Specific requests: _____

_____

Check if patient has: O Pacemaker/AICD device Manufacturer: (If known) _____

O SQ continuous Insulin Pump O MRSA/VRE Hx O Requires interpreter assistance

O Taking: (circle) **Coumadin Plavix Xarelto Pradaxa ASA Eliquis Other:** _____

Office number to contact for questions: _____

Specific person: (if indicated) _____

Physician Signature: _____ Date: _____

Printed Name: _____