Mid-State Health Center

Fax # 536-4001

Pre-op Medical Consultation Request for Mid-State Health Center

Patient Name: _____

Date of Birth: _____

Date of Request: _____

Referring Physician: _____
Print Name

Referring Physician NPI #_____

Patient's Physician/ARNP: _____

Procedure Planned: _____

Date of Procedure: _____

Labs Required: _____

Anticipated Anesthetics To Be Used: _____

☐ **EKG REQUIRED**

Medical issues to be addressed: (Check appropriate box)

- ☐ Heart Disease
- ☐ COPD
- ☐ Diabetes
- ☐ Atrial fib
- ☐ HBP
- ☐ Asthma
- ☐ Multiple Medications
- ☐ Anti-coagulation
- ☐ Other _____