Scott P. Leary, M.D.
Diplomate, American Board of Neurological Surgery
Fellowship Trained, Complex Spine
Surgery Minimally Invasive Spine
Surgery Artificial Disc Replacement
Stereotactic Radiosurgery General
Neurosurgery

Dear Healthcare Provider,

Your patient is to be scheduled for surgery pending clearance.

This will be done:

__ Inpatient (Scripps Memorial Hospital La Jolla)
__ Outpatient (University Ambulatory Surgery Center)

Please examine the patient pre-operatively and confirm the patient is a reasonable risk for surgery.

The following tests are required:

* **EKG (within the last 6 months)**

* **Chest X-Ray (within the last 6 months)**

* **CBC, BMP, PT-INR, aPTT, UA with Microscopic, UC with sensitivity (as seperate order, NOT if indicated) [within 30 days of surgery date]**

- **If you are 70 years old or have a cardiologist, CARDIAC CLEARANCE IS REQUIRED**

- **If you have Type 2 Diabetes, a HgbA1c of <6.9 MUST be OBTAINED in the pre-op phase and MAINTAINED throughout the post-op phase.**

- **If you have any other medical specialist involved in your healthcare, this CLEARANCE is**

__ Required
__ Requested

If any additional tests are needed to ensure the patient will tolerate anesthesia and surgery, please order them accordingly.
If the patient is on any type of anticoagulation medication. please understand and be advised that it will be stopped 7 days prior to surgery and may not be restarted up to 14 days post-op.

** **ALL LABS AND CLEARANCE MUST BE COMPLETED WITHIN 30 DAYS OF THE SURGERY DATE** **

PLEASE FAX ALL LAB/EKG/CXR RESULTS AND LEARANCE AT LEAST 7 DAYS PRIOR TO SURGERY DATE TO OUR OFFICE AT (858) 223-2101. PLEASE NOTE IF NOT RECEIVED THIS MAY RESULT IN A DELAY OR RESCHEDULING OF SURGERY.

Surgical Clearance Form

The patient is under my care and:

A) ____ May proceed with the currently scheduled surgery with no further testing.
B) ____ May proceed with the currently scheduled surgery pending results of additional testing:

_____

C) ____ Surgery needs to be postponed pending results of additional testing:

_____

D) ____ May not proceed with the currently scheduled surgery due to:

_____

E) Additional notes, preoperative, perioperative and/or postoperative instructions:

_____

_____

_____

_____

_____

_____
Physician's Name Printed

_____
Physician's Signature and Date

Physician Order: HgbA1c:

Patient:
Date of Birth:
Date:

– Test to be Ordered: HgbA1c
– Diagnosis
Pre-Op Major Surgery Z01.81
– Physican Order Details 1 Please fax results to 858-223-2101 Attn: Cheyenne
– Physican Order Details 2 Please have this completed ASAP
– Insurance
Primary Insurance:
Secondary Insurance:
– Practitioner Scott P. Leary, M.D.

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