FAX FORM TO: (954) 342.6774
OR EMAIL TO: ADMINISTRATOR@SURGICLEARFLORIDA.COM

MEDICAL CLEARANCE & REFERRAL FORM

Surgeon: ______________________ **Date of Surgery:** ______ / ______ / ______

Procedure:

ICD10: ______________________ CPT: ______________________

Patient Information/Medical History

Patient Name: ______________________ DOB: _____ /_____ /_____ Age: __________
Phone: __________ Street Address: ______________________ Apt #: __________
City: ______________________ State: __________ Zip Code: __________
SS#: __________ Sex: M F Race: __________ Ethnicity: __________ BMI: __________
Allergies/Reactions NKA: ______________________
Past Medical Hx: ______________________
Past Surgical Hx: ______________________

Emergency Information

Emergency Contact: __________ Relationship: __________ Phone: __________

Type of Claim *(please check one)*

☐ PIP: Insurance Company: ______________________ Claim #: __________
Carrier: ______________________
☐ LOP (when PIP benefits are exhausted) ☐Slip & Fall ☐WC ☐Other: __________

Attorney Information

Paralegal: ______________________ Firm: ______________________
Attorney: ______________________ Phone: __________
Address: ______________________
DOI: _____ /_____ /_____ Type of Injury: __________ Prior Injuries: __________

Pre Operatory Order

☐ History & Physical (when you need a REPORT)
☐ LABS: ( ) CBC ( ) CMP ( ) A1C ( ) PT-with INR ( ) PTT ( ) UA with culture ( ) HCG ( ) Other: __________
☐ ( ) EKG ( ) Chest X-Ray ( ) Chest CT ( ) X-Ray: __________ Views: __________
☐ Cardiac Clearance
☐ Pulmonary Clearance
☐ Hematology Clearance
☐ Endocrinologist Clearance
☐ Neurologist Clearance
☐ Nephrologist Clearance
☐ Other: ______________________

Physician Signature: ______________________ Date: _____ /_____ /_____

Please send us the following information *(if available)* to help expedite clearance!
- Medical History (previous/current condition) - Previous Lab Results
- Current Medications - MRI Reports

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Plantation, FL 33324

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REV 6/2025