



Please contact directly at clientservices@fasttrackurgentcare.com

Pre-Surgical Clearance Request

Surgery Being Performed: _____ Surgery Date: _____
 Patient Name: _____ Patient Date of Birth: _____
 Self Pay/Worker's Comp Insurance: _____ Medical Claim #: _____
 Patient Phone Number: _____ Date of Accident: _____

Referring Office/Organization	Attorney Information
Appointment Date Requested: _____	Is there an attorney assigned to the case? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES , please provide the following information: Law Office Name: _____ Attorney Name: _____ Phone Number: (_____) _____ Fax Number: (_____) _____ Email Address: _____
Office/Organization Name: _____	
Phone Number: (_____) _____	
Fax Number: (_____) _____	
Designated Representative Name: _____	

Requested Services		
In addition to an evaluation of the patient to deem "medically fit" for surgery, the following studies are being requested before the patient can have surgery. Please check boxes below.		
Testing <input type="checkbox"/> EKG <input type="checkbox"/> X-ray: Chest <input type="checkbox"/> Additional Imaging: _____	Lab Work <input type="checkbox"/> HCG <input type="checkbox"/> UA <input type="checkbox"/> URINE C&S <input type="checkbox"/> Glucose <input type="checkbox"/> MRSA Screen <input type="checkbox"/> HgB A1c	<input type="checkbox"/> CBC w/ diff <input type="checkbox"/> CMP <input type="checkbox"/> BMP <input type="checkbox"/> PT/PTT w/ INR <input type="checkbox"/> PT/PTT <input type="checkbox"/> Other: _____
Additional Comments: _____		

Request for Medical Records
This completed form authorizes that the patient has provided authorization for release of medical records information necessary for billing or continuity of care. If there are specific records needed for this patient, please check information to be released:
<input type="checkbox"/> All Records <input type="checkbox"/> Diagnostic Imaging <input type="checkbox"/> Progress Note <input type="checkbox"/> EMC Form <input type="checkbox"/> Lab Report
Preferred method to receive requested records: <input type="checkbox"/> Secure Fax at: _____ Attn: _____ <input type="checkbox"/> Mail to: _____