

Surgical Clearance Form

Patient information	
Name	Date of birth
MRN	Date
Procedure	
Medical history	
Allergies	
Current medications	
Past surgeries	
Pre-operation evaluation	

Physical examination**Lab tests****Diagnostic tests****Anesthesia clearance**

Anesthesiologist's name

Assessment

Signature



Remarks

Physician's clearance

Physician's name

Assessment

Signature



Remarks

Surgeon's acknowledgement

Surgeon's name

Signature



Remarks