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	