University of Michigan Preoperative Anesthesiology Clinic

CONSULTANT PHYSICIAN PREOPERATIVE ASSESSMENT FORM

Date: _____

Patient's Name: _____ **UM Registration #:** _____

Surgery Date: _____ **Surgery Type:** _____

Surgical Service _____ **Primary Care Physician:** _____

Specific concerns found in the University of Michigan Preoperative Anesthesiology Clinic:

1. _____ 3. _____

2. _____ 4. _____

Dear Dr. _____:

The above patient is scheduled for surgery at the University of Michigan Hospital. We are requesting your assistance in assessing the medical status of this patient.

To provide the best possible perioperative care, we would like your opinion regarding optimization of this patient's medical condition. Specifically, we would like to know:

- Are the patient's medical problems under optimal control?
- Is the patient functionally impaired due to a medical condition? If so, to what degree?
- What if anything may be done to improve this condition?
- If further evaluation or therapy is warranted, would you like to assume responsibility or would you prefer this be conducted at the University of Michigan.

Please review the following options and indicate, by using a check mark, the most appropriate course of action:

☐ I am satisfied that this patient's medical conditions are optimized and no further diagnostic or therapeutic intervention is necessary

☐ I would like to conduct a preoperative medical workup myself and will forward the results to you

☐ I suggest the following medical workup be conducted at the University of Michigan prior to surgery to assess this patient's medical condition

_____

_____

☐ I suggest the following therapy be conducted at the University of Michigan prior to surgery to assess this patient's medical condition

_____

_____

☐ Please call me at: _____

Please return this form via fax to the University of Michigan Department of Anesthesiology's Preoperative Assessment Clinic at **(734) 647-9978**. Please do not hesitate to contact us with any questions or concerns at (734) 647-9975.

Thank you for your input and assistance.

_____ _____ _____

Physician's Name *Signature* *Date*