



## PRE-OP MEDICAL CLEARANCE REQUEST

FAX TO PREFERRED OFFICE LOCATION

**HELIX Deerfield Beach**  
750 S. Federal Highway  
Deerfield Beach, FL 33441  
P: 954-421-8181 • F: 954-426-2967

**HELIX Lake Worth**  
2311 10th Avenue N.  
Lake Worth, FL 33461  
P: 561-540-4446 • F: 561-540-4430

**HELIX Tequesta**  
1 Main Street  
Tequesta, FL 33469  
P: 561-747-4464 • F: 561-747-5598

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### INSURANCE /CLAIM INFORMATION

Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_  
Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_  
Claim #: \_\_\_\_\_ Date of Accident: \_\_\_\_\_ Authorization #: \_\_\_\_\_  
Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### SURGERY INFORMATION

Surgeon: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_  
Surgery Center/Hospital: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_  
Date of Surgery: \_\_\_\_\_ Date Clearance Needed By: \_\_\_\_\_  
Procedure: \_\_\_\_\_ Body Part/Location: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Anesthesia Type: \_\_\_\_\_

### EVALUATION OR TESTING REQUESTED FOR CLEARANCE

- |  |  |
|--|--|
| <input type="checkbox"/> Routine                                   | <input type="checkbox"/> STAT                                |
| <input type="checkbox"/> Medical Evaluation (History and Physical) | <input type="checkbox"/> CBC w/Differential                  |
| <input type="checkbox"/> EKG                                       | <input type="checkbox"/> BMP (Basic Metabolic Panel/Chem 7)  |
| <input type="checkbox"/> Chest X-Ray                               | <input type="checkbox"/> CMP (Comprehensive Metabolic Panel) |
| <input type="checkbox"/> Pregnancy (Blood)                         | <input type="checkbox"/> PT                                  |
| <input type="checkbox"/> Pregnancy (Urine)                         | <input type="checkbox"/> PTT                                 |
| <input type="checkbox"/> Urinalysis                                | <input type="checkbox"/> Urine Culture                       |

Other Test or Referral Recommended: \_\_\_\_\_

Completed By (PRINT) \_\_\_\_\_ Phone: \_\_\_\_\_