PRE-OP PHYSICAL INFORMATION

FAX BACK TO
Julius DeBroeck, M.D.
281-469-6213

Please obtain the following information from your surgeon prior to your pre-op clearance appointment:

Patient Name: _____

Date of Birth: _____

Planned date of surgery: _____

Surgeon Name: _____

Surgeon Address: _____

Surgeon City/St/Zip: _____

Surgeon Office Phone: _____

Surgeon Office Fax: _____

Surgeon NPI #: _____
(Obtain from surgeon's office)

Surgeon UPIN #: _____
(Obtain from surgeon's office)

ICD-10 Diagnosis code(s) for surgery:
_____

Description of code(s): _____

_____

Pre-Op Clearance letter needed? Y N
EKG needed? Y N
Chest X Ray needed? Y N
Circle labs needed: CBC CMP PT/INR HA1c UA
Additional labs?_____

Pre-Op Clearance letter done: (date) _____

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