New York
New Jersey
Pennsylvania
Connecticut
Georgia
Florida
Texas
California

Pre Op Department
T: (833) 462-5769 Option 4
F: (347) 569-5093
E: labs@goalsplasticsurgery.com

PRE OPERATIVE CLEARANCE REQUISITION

Goals Plastic Surgery requires certain lab tests and medical clearance before you are approved to undergo certain outpatient procedures. The tests help us find possible problems that might complicate surgery if not found and considered beforehand. Safety is our number one priority.

Please bring the following requisition for medical clearance to your physician. All items indicated on the list must be received in order to proceed with your surgical plans.

⚠ **Bloodwork and medical clearance are due at least forty-five (45) days prior to the date of your procedure.**

If you fail to submit the required documents, you will be subject to rescheduling and the assessment of late fees. Please submit labs via fax to 347-569-5093 or via email labs@goalsplasticsurgery.com.

SOLICITUD DE AUTORIZACIÓN PREOPERATORIA

Cirugía Plástica Goals requiere de ciertas pruebas de laboratorio y de una autorización médica antes de que se le autorice a someterse a ciertos procedimientos ambulatorios.

Las pruebas nos ayudan a encontrar problemas potenciales que, si no se hallan con anterioridad, podrían complicar la cirugía y son, por lo tanto, consideradas de antemano. La seguridad es nuestra mayor prioridad.

Por favor, lleve la siguiente solicitud de autorización médica a su médico. Todos los ítems indicados en la lista deben ser recibidos para poder proceder con sus planes quirúrgicos.

⚠ **Los análisis de sangre y la autorización médica deben realizarse al menos cuarenta y cinco (45) días antes del procedimiento.**

Si no presenta los documentos solicitados, se le programará de nuevo la cirugía e incurrirá en una multa por el retraso. Por favor, envíe los resultados del laboratorio por fax al 347-569-5093 o por correo electrónico a labs@goalsplasticsurgery.com.

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GOALS®
AESTHETICS & PLASTIC SURGERY

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To whom it may concern:

This patient will be undergoing an elective cosmetic surgical procedure requiring local anesthesia. We require the following information as medical clearance at least 30 days prior to the patient's scheduled date of surgery:

1. **Lab results** with the following panels, taken no more than **forty five (45) days** prior to the procedure date. Any submissions missing information will be rejected or cause processing delays that can result in rescheduling or cancellation of surgery.
    - **Comprehensive Metabolic Panel (CMP)**
    - **Hepatic Function Panel**
    - **CBC with Differential Platelets**
    - **PT/PTT INR**
    - **HCG Quantitative**
    - **HIV**
    - **Hepatitis Panel**
2. **Completed Office Surgery Pre-Op History and Physical Exam Form**, as attached (2 pages).
3. **If the patient is over 55**, please attach recent EKG or Electrocardiogram.

ICD-10-CM Diagnosis Code Z41.1 — Encounter For Cosmetic Surgery

Kindly fax back the same to our Pre-Op Medical Clearance Team at **(347) 569-5093** or you may email it to **labs@goalsplasticsurgery.com**, with the subject "Medical Clearance."

If you have any questions or concerns, do not hesitate to contact the Pre-Op Department at (833) 462-5769; Menu Option 4.

Very Truly Yours, /s/
Goals: Clinical Team

OFFICE SURGERY PRE-OP HISTORY & PHYSICAL EXAM

Patient Name	Patient DOB

PERTINENT PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS: _____

_____

_____

_____

PHYSICAL EXAMINATION:

Height	Weight	Pre-Op Exam Vital Signs
		BP: **T:** **HR:** **RESP:**

WNL	ABN		Comments
☐	☐	General Appearance	
☐	☐	Mental Status	
☐	☐	Neurological	
☐	☐	Cardiovascular	
☐	☐	Lungs	
☐	☐	Abdomen	
☐	☐	Genitourinary	
☐	☐	Liver	
☐	☐	Extremities	
☐	☐	Integument	
☐	☐	Allergies	
☐	☐	Other	

Tobacco Use: ☐ No ☐ Yes (Frequency: _____)

Current Medication	Dosage	Current Medication	Dosage

PROVISIONAL DIAGNOSIS: _____

_____

_____

Based on my observation / examination, it is my professional medical opinion that the Patient *(select one)*:

☐ Has full medical clearance to undergo elective cosmetic surgery.

☐ May undergo elective cosmetic surgery with the following restrictions: _____

_____

_____

☐ Should not undergo elective cosmetic surgery for the following reasons: _____

_____

_____

Physician Name (Printed)	**Physician License Number**	**Physician License State**
Physician Address (Street, City, State, Zip)	**Physician Phone Number**	
Physician Signature	**Date**	
Physician Stamp		

All fields must be filled and physician stamp is required for medical clearance to be approved.