

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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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](mailto: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
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**PERTINENT PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PHYSICAL EXAMINATION:**

Height	Weight	Pre-Op Exam Vital Signs			
		<b>BP:</b>	<b>T:</b>	<b>HR:</b>	<b>RESP:</b>

WNL	ABN		Comments
<input type="checkbox"/>	<input type="checkbox"/>	General Appearance	
<input type="checkbox"/>	<input type="checkbox"/>	Mental Status	
<input type="checkbox"/>	<input type="checkbox"/>	Neurological	
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	
<input type="checkbox"/>	<input type="checkbox"/>	Lungs	
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	
<input type="checkbox"/>	<input type="checkbox"/>	Liver	
<input type="checkbox"/>	<input type="checkbox"/>	Extremities	
<input type="checkbox"/>	<input type="checkbox"/>	Integument	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	
<input type="checkbox"/>	<input type="checkbox"/>	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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Physician Name (Printed)</b>	<b>Physician License Number</b>	<b>Physician License State</b>
<b>Physician Address (Street, City, State, Zip)</b>		<b>Physician Phone Number</b>
<b>Physician Signature</b>		<b>Date</b>
<b>Physician Stamp</b>		

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