

Date:

Patient:

DOB:

Surgery:

Dear Dr. Medical Provider,

I am requesting medical clearance for the above patient. We have asked the patient to schedule an appointment with you. If you feel the patient requires any testing, this would need to be completed prior to the surgery date with appropriate document clearing the patient for surgery. Please fax this letter with any comments or test results to the number below. Please feel free to contact us with any questions or concerns you may have regarding this patient and the upcoming surgery.

**This patient has been cleared for surgery:**

- Patient is cleared for surgery and medically appropriate for outpatient status
- Patient is cleared for surgery but **requires** overnight observation or inpatient status due to medical factors.

**This patient has NOT been cleared for surgery.**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank you in advance,



J. Trevor Stefanski, MD

Please fax finished form to: Modern Orthopedics at (513) 525-1231

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Surgery Date (if known): \_\_\_\_\_

Evaluating Provider: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**I. OUTPATIENT SUITABILITY CHECKLIST (Check all that apply)**

**General Health:**

- ASA I-II
- BMI  $\leq$ 40
- Ambulatory without extensive assistance
- Cognitively intact
- Reliable home support for 24-48 hours

**Metabolic & Hematologic:**

- HbA1c  $\leq$  7.5-8.0%
- Hgb  $\geq$ 11 (female) /  $\geq$ 12 (male)
- eGFR  $>$ 45
- No active infection
- Anticoagulation manageable for surgery

**Cardiopulmonary Status:**

- No recent cardiac event ( $<$ 6 months)
- No decompensated heart failure
- No uncontrolled arrhythmia
- OSA controlled (brings CPAP if applicable)

**Social Factors:**

- Caregiver available for 24 hours
- Safe home environment
- Transportation arranged

**II. ADDITIONAL NOTES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**III. CLEARANCE DETERMINATION (Provider must select one)**

- Medically appropriate for outpatient joint replacement
- Requires observation/inpatient due to medical factors

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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