Request for Preoperative Optimization Evaluation

The Pre-Anesthesia Assessment and Testing clinic is coordinating the preoperative evaluation and optimization of the patient below for their upcoming surgery. We appreciate your assistance in optimizing and/or risk stratifying the specific medical conditions selected below for this patient.

Provider: _____ Date of Request: _____

Patient Name: _____ DOB: _____ Date of Procedure: _____

Procedure: _____ Location: ☐ Raleigh ☐ Cary ☐ North

Please address any of the following conditions checked below for this patient:

(Please include treatment/evaluation plans either in the space below or as attached office notes. Also include any recent diagnostic studies (ECGs, X-rays), specialist consultations or labs available in your office in the last 12 months)

☐ **Diabetes Mellitus:**

Patient's glucose control is optimized? **Y / N**
If No, further action/treatment recommended: _____
Patient needs additional treatment/medications prior to surgery? **Y / N**
If yes, please detail which medication(s) will be started or adjusted: _____

☐ **Hypertension:**

Patient's blood pressure control is optimizedon current regimen? **Y / N**
If No, further action/treatment recommended: _____

☐ **Pulmonary Disease:**

COPD/Asthma: Pulmonary function is currently optimized? **Y / N**
If No, further treatment or testing recommended: _____

Obstructive Sleep Apnea: CPAP/BiPAP treatment well-titrated? **Y / N**
If No, adjustments or new therapies needed prior to surgery: _____

☐ **Hematologic Disease:**

Patient has a coagulation (hyper- or hypo-) disorder, but is currently optimized and ready for surgery **Y / N**
If No, further treatment or testing required: _____

Patient has history of anemia, thrombocytopenia or other disorder, but is currently optimized and ready for surgery **Y / N**
If No, further treatment or testing required: _____

☐ **Renal Insufficiency:**

Patient needs further treatment/evaluation of Electrolyte disturbance (Na+, K+, etc.) or management of chronic renal insufficiency **Y / N**
If Yes, plan for treatment prior to surgery: _____

☐ **Neurologic Disease:**

Patient has a history of Stroke but is stable and optimized on current treatment? **Y / N**
If No, plan for treatment prior to surgery: _____

Patient has a history of Seizures/Epilepsy but is stable and optimized on current treatment? **Y / N**
If No, plan for treatment prior to surgery: _____

Provider Signature: _____ Date: _____

Fax this completed form and any reports not available in WakeMed electronic record with this form to Pre-Anesthesia Testing Clinic:

Raleigh: 919-350-7554   Cary: 919-350-2285   North: 919-350-6892

Patient Label
placed here

WakeMed
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