

UPMC **LIFE CHANGING MEDICINE**

REQUEST FOR PRE-SURGICAL OPTIMIZATION

SURGERY OPTIMIZATION CLINIC

2005 Technology Parkway
Suite 100 and Suite 300
Mechanicsburg, PA 17050

366 Alexander Spring Road
Suite 2
Carlisle, PA 17015

2501 North 3rd Street
3rd Floor, Landis Building
Harrisburg, PA 17110

2690 Southfield Drive
Suite A
York, PA 17403

Clinic Phone Number: 717-782-4785

Referral Fax Line: 717-703-0145

Date of Referral: _____ DOB: _____

Patient Name: _____ Phone Contact # _____

Procedure: _____

Surgery Date: _____

Surgery Location: Community Osteopathic Harrisburg West Shore Carlisle Lititz York Hanover

Referring Surgeon: _____ Office phone number: _____

Reasons for Optimization:

- | | |
|--|--|
| <input type="checkbox"/> BMI >40 or >35 with 2 comorbidities | <input type="checkbox"/> Impaired Skin Integrity |
| <input type="checkbox"/> HA1C >8 | <input type="checkbox"/> Poor Dentition |
| <input type="checkbox"/> Smoker | <input type="checkbox"/> Numerous Comorbidities |
| <input type="checkbox"/> Other _____ | |

Special Instructions/Surgeon Goals:

Please include the following information with referral:

- Current office notes including allergies and current medications
- Insurance information (*please include medical, dental and prescription*)
- Patient demographics

Patient/Surgeon Pledge

I acknowledge and agree to actively participate in the optimization process to decrease my risk for complications during my surgery. This may include:

- *An office visit in the Surgery Optimization Clinic*
- *Possible appointments and/or additional testing with other health care providers*
- *Phone calls from UPMC Pinnacle to encourage my success*

Patient Signature: _____

Surgeon Signature: _____

UPMC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.