

Perioperative Medicine Clinics

- 520 S. Eagle Rd., Suite 2104, Meridian, Idaho, 83642, Office: 208-706-0201, Fax: 208-706-0202
- 9850 W. St. Luke's Drive, Suite 170, Nampa, ID, 83687, Office: 208-505-2239, Fax: 208-706-0202
- 801 Pole Line Rd. W., Suite 2595B, Twin Falls, ID, 83301, Office: 208-814-2462, Fax: 208-814-2925

This is a request for Internal Medicine to provide risk stratification and patient optimization plans prior to surgery by a St. Luke's Hospitalist provider. ***Please complete and fax this form and associated documentation to (208) 706-0202 for Meridian and Nampa, and 208-814-2925 for Twin Falls.***

Required Information

Clinic Name:

Clinic Contact Person:

Phone:

Referring Provider:

Date

Referring Provider Signature:

Signed:

Referring Diagnosis:

Urgency Assigned by Referring Provider: Urgent Next Available

Patient Information Required

Patient's Full Name:

SSN:

DOB:

Address:

City:

State:

Zip

Best Contact Number(s): Primary:

Secondary:

Other:

Primary Insurance:

ID Number:

Group ID:

Address:

Phone:

Secondary Insurance:

ID Number:

Group ID:

Healthy Connection Provider Information (if applicable): (Provider name, clinic name, Healthy Connection number)

Tricare Referral: Yes No

Surgery Information Required

This information must be included with this consultation request, as applicable, in order to appropriately schedule the patient. Missing information may delay the patient's appointment.

Type of Surgery:

Date of Surgery:

Surgery Location:

Admission Status:

Aspirin Use Preoperatively: Aspirin must be held preop Aspirin may be continued preop and on day of surgery, if necessary, from a medical standpoint

Anesthesia Type: General Spinal TIVA MAC Other

Clinical Indication(s) for Internal Medicine Consult (please use *PPPO Assessment Criteria* for guidance)

Requested Information, if available. Add checkmark if attached.

Last Visit Note:

Medication List:

Recent Labs Date:

Cardiac Studies Date:

EKG Date:

Medical/Surgical History:

Primary Care Provider Name:

Patient Name: _____

Patient DOB: _____

Clinical Indication for Perioperative Medicine referral**Clinical risk factors** (check all that apply):

- History of heart disease
- History of dysrhythmia such as Atrial fib
- History of CHF
- History of stroke or TIA
- Diabetes Mellitus
- Renal insufficiency (creatinine >2)
- Smoker, recent or ongoing, COPD
- History of Asthma requiring daily treatment
- History of OSA or risk for OSA
- Chronic steroid use
- Immunosuppressant medication
- Ongoing anticoagulation with warfarin, novel oral anticoagulants, Plavix, etc.
- Obesity with BMI greater than 30
- Abnormal labs
- Abnormal EKG
- HTN
- Hepatic or pancreatic disease
- Other (please print)