

SURGICAL CLEARANCE REQUEST

Patient Name:	
Date of Birth:	
Type of Surgery:	
Date of Surgery:	

Dr. John D. Wrightson, MD, FAAPMPR has ordered this procedure for our mutual patient in the hope of providing long-term pain relief. Please make us aware of any medication that you prescribe, that we may not be aware that this patient would need to stop prior to surgery, and any other prominent information regarding their health and safety.

Please select from the following options:

- The patient has cardiac clearance for surgery
- The patient is being prescribed _____ from my office,
Medication
- It is okay** for patient to **hold** said medication for _____ days **prior** to surgery and restart medication _____ days **after** surgery.
- The patient **IS** medically cleared for surgery.
- The patient is **NOT** medically cleared for surgery.

COMMENTS:

Please fax your response to the Pain Management Office listed below. Thank you for your dedication and care to our patient.

Physician Signature

Date

John D. Wrightson, MD., FAAPMR

Board Certified: Physical Medicine & Rehabilitation | Fellowship Trained: Sports, Spine & Musculoskeletal
Medicine

3212 Wilmington Road – Suite 20 | New Castle, PA 16105 | **PH: 724-598-2280** | **FAX: 724-598-2282**

www.joshuasonrehab.com

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