SURGICAL CLEARANCE FORM

Patient Name: _____ Date of Birth: _____

Patient Information:

Medical Record Number: _____

Allergies (if any): _____

Current Medications: _____

Surgical Procedure Details:

Procedure Name: _____

Surgeon Name: _____

Scheduled Location: _____

Preoperative Assessment:

The patient has undergone a thorough preoperative evaluation including history, physical examination, and review of laboratory and diagnostic studies. Any abnormalities have been addressed or documented with plans for management.

Medical Clearance:

I hereby certify that I have evaluated the patient named above and find no medical contraindications to proceeding with the planned surgical procedure. The patient is cleared for surgery under the planned anesthesia and surgical conditions.

Restrictions / Conditions:

Any specific restrictions, precautions, or additional instructions related to the patient's medical condition or surgical procedure should be clearly documented here.

Physician Certification:

Physician Name: _____

License Number: _____

Signature: _____

Date: _____

Patient Acknowledgement:

I acknowledge that I have been informed of the nature and purpose of the planned surgical procedure, including the risks, benefits, and alternatives, and that all my questions have been answered to my satisfaction. I consent to the procedure and authorize the surgical team to proceed.

Patient Signature: _____

Date: _____

Witness Certification:

Witness Name: _____

Signature: _____

Date:

This Surgical Clearance Form is intended to comply with all applicable laws and regulations within the United States jurisdiction. It is legally binding and enforceable as part of the patient's medical record. Any disputes arising from this form shall be subject to the exclusive jurisdiction of the courts of the state in which the surgical procedure is performed.

PHYSICIAN'S SIGNATURE **PATIENT'S SIGNATURE** **WITNESS SIGNATURE**

Signature: _____ Signature: _____ Signature: _____