St Luke's Clinic

Perioperative Medicine Consultation Request

Perioperative Medicine Clinics

- 2619 W. Fairview Ave., Suite 2102, Boise, Idaho, 83702, Office: 208-706-1870, Fax: 208-706-0202
- 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 physician. ***Please complete and fax this form and associated documentation to 208-706-0202 for Boise, Meridian and Nampa, and 208-814-2925 for Twin Falls.***

Required Information

Clinic Name:

Clinic Contact Person: | Phone:

Referring Provider:

Referring Provider Signature: | Date 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, <u>as applicable</u>, 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:

Thank you for providing us the opportunity to care for your patients. Please call if you have any questions. Thank you!

Perioperative Medicine Consultation Request

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) _____

Thank you for providing us the opportunity to care for your patients. Please call if you have any questions. Thank you!