The Glow Plastic Surgery || Pascual Surgery Center Medical Clearance
Phone: 703-577-0035
Fax: 571-210-4471

Patient Name: _____ Date of Birth:_____

I, _____(Patient Name) do hereby authorize the release of my medical records and labs to The Glow Plastic Surgery & Pascual Surgery Center.

The physical examination must be completed by the primary care provider and an Official Stamp affixed on the following page. Please attach a copy of the patients latest physical examination and medical history.

_____

Patient Name Patient Signature Date

_____

(The information below must be completed by your Primary Care Provider)

Patient Name: _____ DOB: _____

Height: _____Weight: _____

BMI: _____

T: _____ P: _____ R: _____ BP: _____/_____

Throat: _____

Abdomen: _____

GI system: _____

GU system: _____

Describe any conditions currently being treated: _____

_____

Allergies: _____

Please list any medications the patient is currently on:_____
_____

COVID-19: _____ Negative ; _____ Positive

Required Testing:

CBC
BMP
PT/ INR

*an EKG needs to be done for patients over the age of 48.

Primary Care provider:

Based on the findings above I certify that_____ (patient name) is **cleared / not cleared** *(please circle one)* for the proposed plastic surgery procedure with The Glow Plastic Surgery & Pascual Surgery Center.

_____
Print Name of Primary Care Provider Date

_____
Primary Care Provider Signature

_____
Official Stamp

(Please attach a copy of the patients annual physical labs/report)