



REQUEST FOR PRE-SURGICAL OPTIMIZATION

SURGERY OPTIMIZATION CLINIC

2005 Technology Parkway
Suite 300
Mechanicsburg, PA 17050

366 Alexander Spring Road
Suite 2
Carlisle, PA 17015

2501 North 3rd Street
3rd Floor, Landis Building
Harrisburg, PA 17110

2690 Southfield Drive
Suite A
York, PA 17403

2201 Brunswick Drive
Suite 2200
Hanover, PA 17331

Clinic Phone Number: 717-782-4785

Referral Fax Line: 717-703-0145

Date of Referral: _____ DOB: _____

Patient Name: _____ **Phone Contact #** _____

Procedure: _____

Surgery Date: _____

Surgery Location: Community Osteopathic Harrisburg West Shore Carlisle Lititz York Hanover

Referring Surgeon: _____ **Office phone number:** _____

Reasons for Optimization:

- BMI >40 or >35 with 2 comorbidities
- Impaired Skin Integrity
- HA1C >8
- Poor Dentition
- Smoker
- Numerous Comorbidities
- Other _____

Special Instructions/Surgeon Goals:

Please include the following information with referral:

- Current office notes including allergies and current medications
- Insurance information (*please include medical, dental and prescription*)
- Patient demographics

Patient/Surgeon Pledge

I acknowledge and agree to actively participate in the optimization process to decrease my risk for complications during my surgery. This may include:

- An office visit in the Surgery Optimization Clinic
- Possible appointments and/or additional testing with other health care providers
- Phone calls from UPMC to encourage my success

Patient Signature: _____

Surgeon Signature: _____

UPMC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.