Charles P. Melone, M.D
Steven Beldner, M.D.
Daniel B. Polatsch, M.D.

Hand Surgery Center
321 East 34th Street
New York, NY 10016
212.340.0000

UPPER EXTREMITY SURGERY PRE-OPERATIVE TESTING

PATIENT NAME: ____

SURGERY DATE: ____

Dear Doctor:

The following is a list of testing that is required by Beth Israel Medical Center:

1. ______________ SMA-18
2. ______________ Urinalysis
3. ______________ CBC
4. ______________ PT/APPT
5. ______________ HCG
6. ______________ EKG TRACING (within 6 months of surgery)
7. ______________ CXR Report (Pt. 75 yrs +/within 6 moths of surgery)
8. ______________ Complete H&P w/clearance (see attached form)
9. ______________ Other:____

All of the above results together with the attached H&P w/clearance form must be faxed to:

ATTN: Cecilia Purcell

[ ] Dr. Melone
[ ] Dr. Beldner
[ ] Dr. Polatsch

No later than_________________ FAX # 212-340-0038

IF THE ABOVE IS NOT FAXED WITHIN THE SPECIFIED DATE STATED ABOVE, THE HOSPITAL WILL CANCEL THE SURGERY.

Your prompt attention to the above is greatly appreciated.

If you have any questions regarding the above, please do not hesitate to contact me at 212-340-0000.

Thank you.
Cecilia Purcell
Surgical Coordinator