Surgical Clearance Letter for Lower Extremity Surgery

Tanner Foot & Ankle Clinics

Gary N. Oaks DPM

(801)773-4840 ext. 7368 Phone

(801)525-8758 Fax

Patient Name: _____

Patient DOB: _____ (M/D/Y)

Date: _____

Dr. Gary N. Oaks DPM has contacted me regarding medical stability and the ability to tolerate surgery on the patient named above.

I the below signed Doctor/Provider indicate the patient is:

[ ] medically CLEARED for surgery.

[ ] NOT medically cleared for surgery.

[ ] in need of additional test(s) and or other consultation currently by_____.

[ ] cleared AS THEIR MEDICAL/SURGICAL SPECIALIST, but the patient also needs to be cleared by PCP.

Comments/Additional Notes:

_____

_____

_____

_____ _____ _____

Printed Provider Signature Provider Signature Date (M/D/Y)

When complete please fax the number listed above. Your help is greatly appreciated. Thank You