PRE- TESTING SCHEDULE FORM

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This information is required before scheduling a pre-operative exam by your doctor in the office.

Today's date:______________________

Patient name ___________________________________

Surgeon name __________________________________

Procedure requiring pre-testing _____________________________________

Date of procedure ____

Reason for the procedure ____

Location of facility ____

Type of anesthesia ____

Address and fax # to which medical evaluation is to be sent ____________

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