

Sibley Memorial Hospital
5255 Loughboro Rd., N.W.
Washington, D.C. 20016
(202) 537-4437
www.Sibley.org

Pre-Surgical Testing Center
Monday-Friday 8am-5pm
Closed Saturdays, Sundays and holidays
Fax: (202) 364-7639



**SIBLEY INSTITUTE OF BONE AND JOINT HEALTH
PREOPERATIVE CLEARANCE ORDERS
PHYSICIAN REFERRAL ORDER FORM FOR TOTAL JOINT REPLACEMENT**

Name: _____ DOB: _____ Surgery Date: _____

Procedure: _____

Surgeon: _____ Office Phone: 202-787-5601 FAX: 202-787-5606

The above named individual has been scheduled for joint replacement surgery. We are requesting your assistance in preparing this person for their surgery, by providing a history and physical with the lab work that is listed below.

All pre-operative testing must be performed within the time frames listed below. The results of the testing and exam needs to be reviewed in the Pre-Surgical Testing Center at least **3 days before the scheduled date of surgery**. Fax the results to **202-364-7639 no later than 3 business days prior to the scheduled surgery date**. **The procedure may be delayed or cancelled if the results are not received 3 days prior to the surgery**. Please also FAX results to the Surgeon's office at the number above for their review.

The following are required for all joint replacement patients:

Within 30 days pre-operatively:

- History and Physical

Within 6 weeks pre-operatively:

- CBC with differential
- Complete Metabolic Panel (CMP)
- Clean Catch UA/ Urine C & S
- Nasal Culture for **all** Staph. aureus
- PT/INR (if INR greater than 1.4, retest stat the day of surgery)
- Additional testing: _____

Within 6 months pre-operatively:

- ECG
- Additional Clearance(s): _____

Within 7 days of surgery (**to be done at Sibley Hospital**):

- Type and Screen
- Type and Cross-match _____ units

MD Signature / ID # _____ Date / Time _____