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MEDICAL/SURGICAL CLEARANCE

Patient's Name: _____ **DOB:** _____

CHIEF COMPLAINT	
HX PRESENT ILLNESS	
SIGNIFICANT PAST HX	
ALLERGIES	
CURRENT MEDS	
PHYSICAL EXAM	
BP/RESP/PULSE/TEMP	
HEAD/NECK	
ENT	
EYES	
LUNGS	
CARDIOVASCULAR	
PELVIC	
GI	
EXTREMITIES/SPINE	
NEURO	
SKIN/GLANDS	
DIAGNOSTIC IMPRESSION	
TREATMENT PLAN	

I affirm that the above-named patient is cleared for ENT surgery by Dr. Don Respler

PHYSICIAN NAME: _____ **Speciality:** _____ **NPI:** _____

PHYSICIAN'S SIGNATURE **Phone:** _____ **Date:** _____
 MM / DD / YYYY