CARDIOVASCULAR SPECIALISTS OF NORTH JERSEY

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Pre-Operative Assessment

Patient Name: _____ DOB: _____

Surgery Date: _____

Type of Surgery: _____

PCP Name: _____ Fax: _____

Surgeon Name: _____ Fax: _____

Hospital/
Surgical Center Name: _____ Fax: _____

Attached Documents:

EKG: ____ Physician Note: _____

Echo Report: _____ Nuclear Stress Test Report: _____

Faxed by: _____ No. of Pages: _____Date: _____