Medical Clearance & Referral Form
(Gender Confirmation Chest Surgery & Liposuction)

Patient Legal Name:_____
Patient Date of Birth:_____
Patient Address:_____
Patient Telephone Number:_____

History of Present Illness (HPI): _____
_____
_____

Past Medical History:_____

Past Surgical History:_____

Family History:_____

Social History:_____

Current Medications:_____

Allergies:_____

Physical Exam: (circle Normal or enter detailed exam)

HEENT: Normal / _____

Heart: Normal / _____

Lungs: Normal / _____

Abdomen: Normal / _____

Extremities: Normal / _____

Neurological: Normal / _____

Psychiatric: Normal / _____

Assessment/Plan:_____

Patient is medically cleared to undergo the proposed procedure under General Anesthesia (circle): YES / NO

Patient labs and consultations have been reviewed and are attached on a separate paper (circle): YES / NO

I certify the above is true and correct, to the best of my knowledge, and have completed this form to serve as a referral of the patient to Charles Garramone, D.O., FACOS, a Board Certified Plastic & Reconstructive Surgeon in the State of Florida, as a specialist in the procedure for Gender Confirmation Chest Surgery and liposuction to be performed by Dr. Charles Garramone on the above mentioned patient., even though other physicians in their state of residence may perform the same procedure. This also serves as a complete medical history and surgical clearance. Any additional paperwork should be attached or forwarded to our office. You may email this completed form and attachments to frontdesk@drgarramone.com or fax to (954) 473-2454.

Referring Physician Signature: _____**Date:**_____

Referring Physician Name: _____
Office Address:_____
Office Telephone:_____

