Medical Clearance Form for the FTM Top Surgery® Procedure (Female to Male Gender Reassignment Chest Surgery)

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 medical history and surgical clearance for FTM Top Surgery® Procedure (Female to Male Gender Reassignment Chest Surgery) to be performed by Dr. Charles Garramone on the above mentioned patient. Any additional paperwork should be forwarded to our office. You may email this completed form to frontdesk@drgarramone.com or fax to (954) 473-2454

Physician Signature:_____**Date:**_____

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

