Request for Pre-Op Risk Assessment Cardiovascular Services

Please fax form to the MercyOne Iowa Heart Center with the patient's records.

Patient Name (First, Middle, Last): ______________________________

Patient Date of Birth: ______________________

Preferred Appointment Location*:*

- ☐ **Ames** (P: 515-232-2500, F: 515-246-4479)
- ☐ **MercyOne Campus/Laurel** (P: 515-235-5000 F: 515-288-6713)
- ☐ **Ankeny** (P: 515-643-7777 F: 515-643-7781)
- ☐ **Carroll** (P:712-792-6500 F: 515-246-4481)
- ☐ **Fort Dodge** (P: 515-574-8700 F: 515-246-4482)
- ☐ **Ottumwa** (P: 641-682-5349 F: 515-246-4474)
- ☐ **Iowa City** (P: 319-339-3400 F: 515-280-4618)
- ☐ **West Des Moines** (P: 515-633-3600 F: 515-288-0840)
- ☐ **Newton** (P: 641-841-1400 F: 515-362-4147

Risk Assessment

Date of Surgery: ______________________________

If unscheduled, select priority: ☐ <1 Month ☐ 1-3 Months ☐ 4-6 Months

Reason for Risk Assessment: ______________________________

Surgical Procedure: ______________________________

Type of Anesthetic: ______________________________

Surgeon: ______________________________

Diagnosis for Surgery:______________________________

Surgical Complexity (Low/Mod/High):______________________________

Procedural Bleeding Risk (Low/Mod/High) ______________________________

Medications requested to be held: ______________________________

Primary Care Provider: ______________________________

Requesting Office Phone Number: ______________________________

Requesting Office Fax Number: ______________________________