Pre-operative Services ***444 9404***

LapBand® Consultation

Pt Name
Pt IDN
Encounter Number
BDay

From: __________________ Date: __________________

The above listed patient is scheduled for elective _________________________surgery.
Date of surgery: ______________
Patient phone number:_________

Please evaluate the need for deflation of the Lapband® prior to possible general anesthesia.

Thank you
Preoperative services MD:_______________ phone: 444-9404 fax: 444-1211

Date of lapband® surgery:___________

Needs deflating: Yes No

If yes, please confirm the date of deflation: __________

Already deflated:__________

Any further work up needed or recommendations? Yes No

Name: ___________ Sign: ____________ Date: __________ Phone: ___________