Dan Hibbert Urology, PC
Ph# 801-260-3010 Fax# 801-254-8331

Surgical Clearance Form

Patients Name:_____

Patients DOB: _____

Type of Surgery:_____

Expected Date of Surgery:_____

Dr Clearance is Needed From:_____

Provider:
Please mark the appropriate box below and sign.

☐ This patient is cleared for surgery.

_____ _____
Physician Signature Date

☐ This patient is NOT cleared for surgery.

_____ _____
Physician Signature Date