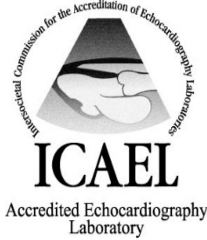
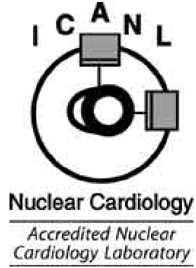
William M. Hudson, M. D., F.A.C.C., P.C.

Cardiovascular Medicine

110 Samaritan Drive
Suite 101
Cumming, Georgia 30040





Date: _______________

To: ____ **at Fax:** _________________________

RE: (*patient*) ____**DOB:**______________________

Dr. William Hudson has been notified that the above patient will need cardiac clearance for an upcoming procedure /surgery by the above physician/surgeon.

In order to properly evaluate the above patient Dr. Hudson requests the below information from your office.

Please fill out the below information and fax back to Dr. Hudson's office.

*****Cardiac clearance cannot be completed without the below requested information***

Date: _________________

Physician requesting cardiac evaluation: ____

Phone: ____________________________ **Fax***:** ____________________________________

**** please note: due to confidentiality regulations we will fax completed pre-op evaluation form to the surgeon only. Surgeon's office should fax form to appropriate facility if needed*

Patient Name: ______________________________________ **DOB:** _______________________

Surgery / Procedure: ____

Date of surgery: _____________________________________

Facility where surgery will take place: ____

Type of Anesthesia: ____

Name of person completing form (please print) ____

Telephone: 770.887.0472 *Facsimile: 770.887.1140*