SURGERY/PROCEDURE APPROVAL FORM

Provider Name: _____

Patient Name: _____

Surgery/Procedure: _____

Date of Surgery/Procedure: _____

Evaluation Criteria:

1. Will delay of this Surgery/Procedure pose a threat to the patient's life?

   YES □ **NO** □

2. Will delay of this Surgery/Procedure pose a threat of permanent dysfunction of an extremity or organ system?

   YES □ **NO** □

3. Will delay of this Surgery/Procedure risk metastasis or progression of staging?

   YES □ **NO** □

4. Will delay of this Surgery/Procedure pose a risk of rapidly worsening patient's severe symptoms?

   YES □ **NO** □

5. Will delay of this Surgery/Procedure otherwise cause undue risk to the current or future health of the patient?

   YES □ **NO** □

If any answer to question 1-5 above is "YES" provide support for your answer:

_____

_____

Provide additional support and a brief description of any additional circumstances surrounding the immediate need for the surgery/procedure:

_____

_____

THIS FORM MUST BE SUBMITTED PRIOR TO THE DATE OF THE SURGERY/PROCEDURE

Committee's Determination:

□ **Surgery is Non-Essential based on the review of this information and the patient's medical record**

□ **Surgery is Essential under the criteria set out above based on the review of this information and the patient's medical record**

Date: _____

_____

Medical Director Signature on Behalf of the Committee