**MARCUS FORD, M.D.**
Joint Replacement Surgery
Reconstructive Surgery of the Hip and Knee

**To Whom it May Concern:**

I have scheduled _____ D.O.B. _____

for a _____.

To ensure the best possible outcome, I do require that the patient be evaluated by their **PCP / Medical Specialist** for medical clearance. The patient has been informed that the clearance process cannot eliminate all risks and is simply intended to ensure chronic medical conditions are under reasonable control.

Please arrange a visit to have the following labs done **CBC/DIFF, CMP, A1C, PT, PTT, and EKG**. Please have these done within **30 days** of surgery. Please forward a copy by fax along with written clearance to us at 817-346-4430.

**Diabetic patients are required to have a hemoglobin A1C within 90 days of surgery. If test result is 7.5 or greater surgery may be postponed.**

Thank you very much for your assistance in this patient's care.
If you have any questions, please do not hesitate to contact me or my nurse, Jasmine at 817-877-3432.

Sincerely,
Marcus Ford, M.D.

**Please complete the following, if appropriate, and fax it to # 817-346-4430 or 817-346-4394.**

Date: _____

Upon Examination, I find no contraindications to the upcoming surgery.

Printed name of physician_____

Signature_____

Phone number _____

**THE TEXAS HIP AND KNEE CENTER**
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