Surgical or Medical Justification for Procedure Form

I, Dr. ____ MD/DO need to perform on ___/______/______

The following procedure: ____

____

____

____

____

On patient: ____

D.O.B.: __/____/______

The reason this procedure is urgent or cannot be postponed is: ____

____

____

____

The condition the patient has that must be addressed in an urgent manner is: ___________________________________

____

____

Physician Signature: ____ Date: ___________ Time: ___________

Patient Identification/Label