



**CARDIOVASCULAR
SPECIALISTS
OF NORTH JERSEY**

954 TEANECK ROAD, TEANECK, NJ 07666
PHONE: 201-833-2300 | FAX: 201-833-7600
WWW.CARDIOVASCULARSPECIALISTSNJ.COM

STEPHEN J. ANGELI, MD, FACC
GERARD T. EICHMAN, MD, FACC
TARIQSHAH M. SYED, MD, FACC
DAVID M. WILD, MD, FACC
SHALIN P. DESAI, MD

Pre-Operative Assessment

Patient Name: _____ **DOB:** _____

Surgery Date: _____

Type of Surgery: _____

PCP Name: _____ **Fax:** _____

Surgeon Name: _____ **Fax:** _____

**Hospital/
Surgical Center Name:** _____ **Fax:** _____

Attached Documents:

EKG: ____ **Physician Note:** ____

Echo Report: ____ **Nuclear Stress Test Report:** ____

Faxed by: _____ **No. of Pages:** _____ **Date:** _____

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