REQUEST FOR PRE-SURGERY EVALUATION

We would appreciate your evaulation of the following patient for surgery. Listed below are the requirements for the surgery center..

Surgery Center guidelines: ***Labs:*** *CBC/Comprehensive Metabolic Panel / Fasting for Diabetic* ***(within 6 months of surgery)***

EKG: *(only needed if any history of heart problems* ***within 6 months*** *of surgery date)*

Surgery Clearance: (This Form to be filled out.)

Health and Physical for:

PATIENT NAME: ____________________ **DOB:** ______________

Surgery Date: ____________________ **Eye:** __________ **Surgeon:** ____________________

SURGICAL PROCEDURE ____________________ **CHIEF COMPLAINT:** ____________________

CPT: ____________________ ICD 10: ____________________

The anesthesia that will be used is ***IV Sedation/Topical***

If your patient is on any type of blood thinner, we do ask that they stop 1 week prior to surgery.
If for some reason that is contraindicated, please let us know. Thank you.

Drug Reactions:

Current Medications:

Past Surgeries:

Medical History:

Assessment:

Plan:

PHYSCIAL EXAM

HEIGHT: WEIGHT: TEMP: PULSE: R: B/P:

	NORMAL	ABNORMAL			
HEENT					
C-V SYSTEM					
LUNGS					
M-S SYSTEM					
NEUROLOGIC					
PSYCHO-SOCIAL					
OTHER					

SURGERY CLEARD FOR: **Local:**__________ **General:**__________ **Choice:** __________

Doctors Signature: ____________________ **Printed Name:** ____________________

If Nurse Practitioner does H&P, it must be signed by the doctor.

EXAM DATE: ____________________

Please fax <u>THIS COMPLETED FORM</u> along with <u>LABS</u> and <u>EKG</u> to 214-360-0083 or 214-765-9475.

We need **ALL** information at least **3 days prior to surgery**.

Thanks again,

Kimberly Moreno & Genna Martinez, COA

Surgical Coordinators