RETINA AND UVEITIS CENTER

MUGE R. KESEN, MD
8260 Greensboro Dr., Ste A-20
McLean, VA 22102
P: 703-719-2040; F: 703-719-2041

MEDICAL CLEARANCE REQUEST

TO PRIMARY CARE PHYSICIAN OF:

PATIENT NAME: _____

DOB: _____

DATE OF SURGERY: _____

This form must be returned to us at least 48 hours prior to the patient's surgery, or it will have to be rescheduled. Please FAX back to: **(703) 719-2041**

THANK YOU FOR YOUR ASSISTANCE.

If you have any questions or the patient cannot be medically cleared for surgery, please call the number above for the surgeon.

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HISTORY AND PHYSICAL FORM

THIS FORM MUST BE COMPLETED WITHIN 30 DAYS OF SURGERY DATE. A NEW FORM MUAT BE COMPLETED, IF THIS FORM IS OVER 30 DAYS OLD.

PATIENT: _____

DOB: _____

DIAGNOSIS:

_____

PROCEDURE:

_____

NOTE TO PATIENT:

You must have medical clearance before surgery can be performed. If you have had recent physician exam, your primary care physician may complete this form. If you have not had a recent exam, you will need to have one and have your physician complete this form and return it to our office.

NOTE TO PHYSICIAN:

Please perform a physical examination on this patient, and complete and return this form to our office.

If the patient has had a recent exam, a physical is only required if you feel it is necessary.

If patient is at least 50 years of age or has history of cardiac problems, please perform an EKG. (If one was done in the last 3 months and the patient has no cardiac problems, please send a copy of that EKG.)

Diabetics need a fasting blood sugar testing.

Females of childbearing age require a Urine HCG.

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BLOOD THINNERS:

With primary care physician's and/or cardiologist's approval:

ASPIRIN, PLAVIX, and AGGRENOX should be stopped 7 days prior to surgery

COUMADIN and ELIQUIS should be stopped 5 days prior to surgery

PRADAXA should be stopped 3 days prior to surgery

XERALTO should be stopped 2 days prior to surgery

HISTORY AND PHYSICAL FORM

PATIENT: _____ DOB:_____

DATE OF SURGERY: _____

Patient is scheduled to undergo:

Anesthesia: Local with MAC General

Please list your findings upon examination:

BLOOD PRESSURE:

_____

ALLERGIES:

_____

HENT:

_____

HEART:

_____

LUNGS:

_____

ABDOMEN:

_____

EXTREMITIES:

_____

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PLEASE LIST SIGNIFICANT MEDICAL PROBLEMS AND MEDICATIONS:

DIAGNOSIS	MEDICATIONS

_____THIS PATIENT IS MEDICALLY CLEARED FOR THE PROPOSED SURGICAL PROCEDURE IN AN AMBULATORY SURGRY CENTER OR HOSPITAL AND NEEDS NO FURTHER THERAPEUTIC INTERVENTION OR DIAGNOSTIC WORK-UP.

_____THIS PATIENT IS NOT MEDICALLY STABLE FOR SURGERY.

PHYSICIAN'S NAME: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____