Dr. Neil F. Notaroberto, M.D.
Dr. Arley G. Jaramillo, M.D.
Dr. Jaime W. Wang, O.D.

EyeCare 20/20
Retina & Vision Center

Harahan - Mandeville - Slidell
1-800-680-3932
www.EyeCare2020.org

Surgical Clearance Form

DATE:_____

PATIENT'S NAME:_____

TENTATIVE SURGERY DATE:_____

SURGEON:_____

Dear Dr._____

The above named patient is scheduled for **cataract surgery**. This will be performed with careful monitoring which includes anesthesia and Registered Nurses.

In order to provide this patient with the best possible care during their surgical procedure, please complete the enclosed patient history form. Diagnostic testing is not required unless you feel it is medically necessary. If you do perform any blood work or EKG, please provide the results to us.

Please fax this form to our office at least one week prior to the surgery date.

FAX TO: 985-641-2790

If you have any questions, do not hesitate to call us at 504-737-3456. Thank you for your prompt attention to this matter.

PATIENT HISTORY

PATIENT NAME:_____ AGE:_____

ALLERGIES:_____

EXAMINATION DATE:_____ SURGEON:_____

BP:_____PULSE:_____RESP:_____TEMP:_____

PAST MEDICAL HISTORY:_____

CURRENT MEDICATIONS:_____

GENERAL APPEARANCE:_____

HEART:_____

LUNGS:_____

EXTREMITIES:_____

LAB DATE:_____

HGB:_____ HCT:_____

PLT:_____

GLUCOSE:_____ Na:_____ K:_____

BUN:_____ CR:_____

SIGNIFICANT OTHERS:_____

EKG:_____

(Please send an interpreted copy if done)

[ ] Cleared for Surgery Valid for _____ weeks

[ ] Is not cleared due to:_____

[ ] Referred to _____ for lab [ ] EKG [ ]

Cleared by: _____