



Surgical Clearance Form

PATIENT'S NAME: _____

PATIENT'S DOB: _____

TENTATIVE SURGERY DATE: _____

SURGEON: Omar Krad, MD

Dear Dr. _____

The above named patient is scheduled for **Cataract** Surgery .
Typically, IV conscious sedation is performed under the supervision of an anesthesiologist and team of RN's.

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 try to send this form to our office at least **one week prior** to the surgery date.

FAX TO: (714) 526-2020

OR

EMAIL TO: help @ HopeCataract.com

If you have any questions, do not hesitate to call us at **714-879-0020**. Thank you for your prompt attention to this matter.

PATIENT HISTORY & PHYSICAL

EXAMINATION DATE: _____

PATIENT NAME: _____ DOB _____

ALLERGIES: _____

BP: _____ PULSE: _____ RESP: _____ TEMP: _____

PAST MEDICAL HISTORY: _____

CURRENT MEDICATIONS: _____

GENERAL APPEARANCE: _____

HEART: _____

LUNGS: _____

EXTREMITIES: _____

Significant **LAB** Findings: _____

EKG Findings: _____

(Please send copies if done)

Cleared for Surgery Valid for _____ weeks

Is not cleared due to: _____

Referred to _____ for labs EKG

Cleared by: _____
Provider Name & Signature