REQUEST FOR CLEARANCE

Newport Eye Center

Voice: 949-644-0239

Fax: 949-644-0461

Date: _____

Dear Doctor: _____

I am requesting a consultation for **Cataract Surgery**.

Please provide the information indicated on the accompanying sheet, provided by the surgery center.

Clearance is requested for:

- o Local Anesthesia (MAC)
- o General Anesthesia

EKG **dated within 1 year** of surgery is required for clearance.

H&P form must be **dated within 30 days** of surgery:

☐Patient is scheduled for first eye on: ____/____/____.

☐Patient is scheduled for second eye on: ____/____/____. (Will need **updated clearance within 30 days** for second eye.)

Thank you,

Robert L. Jones M.D. F.A.C.S. (UPIN A52018)

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

Patient Name:_____ Date of Birth:_____

Chief Complaint/Indications: _____

_____

Allergies: _____

Current Medications: _____

MEDICAL HISTORY

	N/A	No Pertinent History
Heart	☐	☐
Lungs	☐	☐
Patient/Family Bleeding/Coagulation History	☐	☐

Other Pertinent Medical History:

PHYSICAL

	No Significant Findings	Findings
Heart	☐	
Lungs	☐	

Examination of Area of Proposed Surgery/Invasive Procedure:

LABORATORY

Pertinent Labs/Diagnostic Tests: ☐ Yes ☐ No Reviewed: ☐ Yes ☐ No

☐ Refer to dictated/office History and Physical for complete assessment.

ANESTHESIA/SEDATION PLAN ***Complete this section for invasive procedures using sedation if Anesthesiologist is not in attendance.***

History of previous adverse effects of anesthesia or sedation? ☐ Yes ☐ No Describe: _____

ASA physical status score: ☐ ASA I ☐ ASA II ☐ ASA III ☐ ASA IV (See other side for definition)

Airway Assessed: ☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4 (See other side for definition)

Sedation/Anesthesia Plan: ☐ None ☐ Local ☐ Deep – Anesthesiologist must be in attendance.

☐ Moderate Sedation: The sedation risks, benefits, and alternatives have been discussed, understood and accepted by the patient or appropriate decision maker.

DIAGNOSIS/PLAN

Pre-Operative/Pre-Procedure Diagnosis:_____

Planned Treatment/Procedure: _____

Date:_____ Time:_____ Physician Signature: _____

ADMISSION UPDATE

Complete, date, time and sign this section if the history and physical examination was performed prior to admission.

☐ History and Physical reviewed and patient examined

☐ No change in patient since History and Physical was performed

Changes in patient's condition are as follows: _____

_____

_____

_____

_____

Date:_____ Time: _____ Signed By: _____