DR. JOSEPH WALRATH - OCULOPLASTIC SURGERY - COORDINATOR: 770-804-1684 EXT. 119 / 166 FAX: (844) 742-6584

PREOPERATIVE RISK ASSESSMENT / CLEARANCE FORM

-- PATIENTS: PLEASE HAVE THIS COMPLETED WITHIN ONE MONTH OF THE PROCEDURE DATE --

Dear Medical Doctor,

Thank you so much for your assistance in providing preoperative guidance and clearance! Our patient would like to undergo the following:

_____ Anesthesia: ❑ Monitored ❑ General Duration: _____ hrs / min

Ideally, I would like our patient to hold ASA for 2 weeks, Plavix (and related) for 10 days, Coumadin for 5 days, and other blood thinners as appropriate. For general anesthesia, I require that patients hold metformin for 2 days prior to the procedure. If any of these requirements are problematic, please give me your recommendations. Thank you!

PATIENT NAME: _____ **MEDICATIONS** **DOSE**

DATE OF BIRTH: _____

DRUG ALLERGIES:

?LATEX ALLERGY: NO❑ YES❑

PHYSICIAN COMPLETING FORM: **OFFICE #:**

BP: _____ **HR:** _____ **T:** _____ **RR:** _____ **SaO2:** _____ **Gen. Appearance:** _____

	Normal	FINDINGS	HISTORY:
SKIN			SURGICAL:
LYMPHATICS			
HEENT			
NECK			
BREASTS			MEDICAL:
CHEST/LUNGS			
HEART RHYTHM			
HEART MURMUR			
VASCULAR			
ABDOMEN			
EXTREMITIES			TOBACCO / ETOH:
NEUROLOGICAL			FAMILY Hx:

Cleared for surgery: **YES ❑** **NO ❑** **Comments**

Signature:

Date: