

PREOPERATIVE RISK ASSESSMENT / CLEARANCE FORM

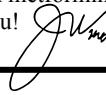
-- PATIENTS: PLEASE HAVE THIS COMPLETED WITHIN ONE MONTH OF THE PROCEDURE DATE --

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 <input type="checkbox"/> YES <input type="checkbox"/>		
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: