_____CATARACT and LASER CENTER, LLC_____

Frank R. Owczarek, M.D.

To Our Patient: ***Please give this letter and history and physical form (on the reverse side) to your primary care physician so they may clear you for your surgery. We recommend you request a copy for your records.***

Patient Name:_____

Surgical Procedure:

- ☐ Cataract
- ☐ Laser Treatment
- ☐ Other:_____

Date of Procedure:_____

Our mutual patient will be undergoing the above referenced surgical procedure at the Cataract and Laser Center. Guidelines state that all surgical patients are required to have a **history and physical** form completed from their medical doctor no more than 30 days prior to the procedure. Due to the nature of the surgery, we do not require an EKG or blood work. The patient needs to be cleared for surgery in an ambulatory surgical center using topical anesthesia.

We ask that you fax the completed form to 302-454-1329 no less than two (2) working days prior to the date of surgery.

If you have any questions, you may contact a member of our nursing staff at 302-454-8802.

4102 Ogletown-Stanton Road , Suite 1 ● Newark, DE 19713-4181 ● (302) 454-8802 ● Fax (302) 454-1329

Rev. 1/12

CATARACT AND LASER CENTER, LLC PATIENT HISTORY AND PHYSICAL

Patient Name: _____ **Date of Birth:** _____

Allergies: _____ Latex Allergy: yes / no

Medications and Dosages: Attached List: ☐

Blood Thinner: yes / no Aspirin: yes / no Alpha-blocker: yes / no

Medical History:

Surgical History:

Social History: Smoker: yes / no ETOH Use: yes / no Drug Use: yes / no

Review of Systems:	WNL	Abnormal Findings
Constitutional		
Head/Neurological		
EENT		
CV		
Respiratory		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Endocrine/Hematologic		

Physical Exam: BP: _____ R / L P _____ R _____ T _____

Head/Neuro:	Resp:
Neck:	Skin:
CV:	M/S:

Diagnosis:

Pt is cleared for surgery in an ambulatory setting: ☐ Pt is cleared for Topical and/or Local Anesthesia: ☐

Signed: M.D., D.O., N.P., P.A. Date:

Printed Name: Fax to: 302-454-1329