CARDIAC CLEARANCE REQUEST

Date: _____/_____, 20__ __

Dear Dr. _____
Cardiologist

Re: Our mutual patient: _____ DOB: _____/_____/_____

The patient ☐is or ☐will be, scheduled for surgery on _____, 20__ __

Requiring a ☐ MAC or ☐ General anesthetic.

Length of Procedure: _____ ☐Hours _____ ☐ Minutes

We are requesting Cardiac Clearance for:

Procedure:

_____

_____

_____ Patient needs the following prior to risk stratification:

_____

_____

☐ Patient is ***at low risk*** for surgery from a cardiac standpoint.

☐ Patient is at ***increased*** risk but not prohibitive risk from a cardiac standpoint. To minimize risk, we recommend the following:

1. _____
2. _____
3. _____

☐ Patient is at ***prohibitive*** risk from a cardiac standpoint for the above procedure.

Patient ☐ May ☐ May Not stop Plavix/ASA _____days before procedure.
Patient ☐ May ☐ May Not stop Coumadin _____ days before procedure.
Patient may restart Coumadin/Plavix/ASA _____ days post procedure.

_____ ( ) _____-_____
Cardiologist Signature Telephone Number

_____, 20__ __
Date

PLEASE FAX COMPLETED FORM ASAP TO COMMUNITY SURGERY CENTER NORTHWEST @ (317) 621-3016. ANY QUESTIONS PLEASE CALL (317) 621-3010.

Revised3/1/13