EPS Surgical Medical Clearance Form

Medical clearance is needed from your primary care physician **before your date of surgery.**

Your primary care physician should complete the attached form. Please

print a copy and take to your primary care physician's office for them to complete. **We ask that you assist us in ensuring your primary care physician completes this form in a timely manner.** If you are unable to take to their office, please direct them to our website at www.companyname.com,and click on **Surgical Patient Forms**.

Upon completion of the form, please fax to: Attention: VIP Services
Fax # (404) 294-3353
Alternate Fax # (404) 294-9361

If you have any questions, please contact us via phone at (404) 292-2500.

EYE PHYSICIANS & SURGEONS, PC
1457 Scott Blvd Decatur, GA 30030 Phone: 404-292-2500 Fax: 404-267-6709

Pre-op Evaluation

Charles W. McDowell, Jr, MD
Peter A. Gordon, MD
Paul McManus, MD
John Thomas, MD
Laura Bealer, MD
Indira Menon, MD
Ajeet Dhingra, MD
Christina Weeks, MD

TO DR. _____ Voice # _____ Fax # _____

_____ Voice # _____ Fax # _____

This patient is scheduled for eye surgery in the near future. Should you choose to see this patient in your office to provide surgical clearance, please ask your office personnel to contact the patient directly. Please fax your evaluation and any supporting documentation as soon as completed.
Thank you! Your assistance is greatly appreciated!

PATIENT'S NAME_____

PATIENT'S PHONE (HOME) _____ (CELL)_____

x

BIRTHDATE_____PRE-OP DATE_____

DIAGNOSIS_____SURGERY DATE_____

PROPOSED SURGERY_____ANESTHESIA_____

CC: _____

Significant past medical history:

_____

_____

_____

List of previous operations:

_____

_____

_____

Current Medications with Dosages:

_____

_____

Drug & Food Allergies:

_____

_____

B/P:_____**Pulse:**_____

HEENT_____

LUNGS_____

CARD/VASC_____

ABD_____

EXT_____

NEURO/PSYCH_____

DIAGNOSES_____

Remarks:_____

Is this patient cleared to have surgery? _____

Date:_____ **Signed:**_____**, M.D.**