Analisa Arosemana, MD
Virgil E. Sklar, MD
Rashid M. Taher, MD

MEDICAL CLEARANCE REQUEST

Date: _____

Patient Name: _____
DOB: _____

The above stated patient is scheduled for surgery and requires:

- Preoperative Medical Clearance including FULL H&P
- Electrocardiogram
- Laboratories: BMP, CBC, PT/PTT
- Radiology: CHEST X- RAY if required by PCP
- STOP ANTICOAGULATION if approved by PCP/cardiologist:

_____

Preoperative Diagnosis (ICD-10): _____
Planned Date of Procedure: _____
Facility: _____
Rendering Provider: _____

PLEASE FAX MEDICAL NOTE SHOWING CLEARANCE AND ALL PRE-OP CLEARANCE RELATED DOCUMENTS TO:
FAX: 305-854-4065 or email to : contactus@eliteeyemd.com