Oklahoma
EYE SURGEONS
Steven R. Sarkisian, Jr., MD

Surgery Clearance Request

Date:_____

To: _____ **Phone#:** _____ **FAX#:**_____

From: Steven Sarkisian, M.D.

Regarding Patient:_____ **DOB:**_____

Date(s) of Surgery:_____

_____*i*s scheduled for eye surgery with_____anesthesia on the above listed date(s).
She is on the following blood thinners and ideally, we would like to discontinue blood thinners 2-5 days prior to surgery, if it is safe for the patient.
Please indicate if it is safe for this patient to stop their blood thinners.

		Please Circle yes or no	***How many days prior to surgery can they stop the medication?***	***When should they resume the medication?***
	Aspirin	Yes/No		
	Plavix	Yes/No		
	Coumadin	Yes/No		
	Other:	Yes/No		

We need your medical evaluation in order to proceed with this patient's surgery.
Please indicate all that apply:

_____Pt is stable and optimized and ready to proceed with surgery in an Ambulatory Surgery Center.

_____Pt is stable and optimized but needs the following limitations or or instructions: _____

_____Pt is not stable or optimized and is not authorized to proceed @ this time due to the following reason: _____

Authorizing Physician _____ Date_____

Please call Richard if you have any questions or concerns with regard to this patient, @ (405) 942-5571 or FAX to (405) 942-0115 ATTN to Richard. Thank you!