Pre-Operative Clearance

Please bring forms to your PCP to be completed.

Patient Name: _____ Surgery Date: _____

Surgeon: _____

Thank you for seeing the above patient for pre-operative clearance for
Nashua Eye Associates and Novamed Surgery Center of Nashua.

Our guidelines are as follows:

- Pre-Operative evaluation
- EKG to be completed at the discretion of PCP
- Chest x-ray to be completed at the discretion of PCP
- Bloodwork to be completed at the discretion of PCP

- Diabetics- Please provide instructions for insulin or oral medications for day of surgery.
- Anti-Coagulants & ASA- It is not necessary to discontinue unless requested.
    - Please provide the latest INR for Coumadin patients.
- Forward recent cardiac work-up and/or tests, and recent pacemaker report.

When cognitive impairment is present, please indicate if an activated DPOA is in place.

Completed forms can be faxed to 603-689-9230 or 603-689-9326.

If there are any questions, please feel free to reach out to one of
our surgical coordinators at 603-882-9800, Ext 8015

History and Physical Examination Form

To be filled out by Primary Care Physician

Patient Name:_____ DOB:_____ Age:_____ Sex:_____

Pre-Op Diagnosis:_____ Proposed Surgery:_____

Allergies:_____ Habits: Smoker ETOH Other

Medications and Dosages:_____

_____

_____

Past Medical History:

POS	NEG		COMMENTS
		TB	
		Neurologic Disease	
		Cardiac Disease	
		Liver Disease	
		Lung Disease	
		Diabetes	
		Bleeding	
		GI Disease	
		Kidney Disease	

Physical Examination:

HT:_____ WGT:_____ B/P:_____ P:_____ General Appearance:_____

POS	NEG		COMMENTS
		HEENT	
		Glands	
		Thyroid	
		Abdomen	
		Extremities	
		Lungs	
		GU	
		Heart	
		Spine	
		Neuro	

Note: When Cognitive impairment is present, please indicate the patient's ability to make medical decisions and provide consent for procedures. Competent Not Competent Activated DPOAH in place

DATA (LABS, EKG, ETC)_____

If patient is on Coumadin or Warfarin therapy, provide latest INR. INR:_____ Date:_____

IMPRESSION:_____

After examining the patient and reviewing the preoperative data, I find this patient to be medically stable for the proposed surgery in the ASC setting.

Signature:_____ Date:_____

Printed Name: _____ Telephone:_____