DR. JOSEPH WALRATH - OCULOPLASTIC SURGERY - COORDINATOR: 770-804-1684 EXT. 119 / 166 FAX: 770-804-1679

# PREOPERATIVE RISK ASSESSMENT / CLEARANCE FORM

***-- PATIENTS: PLEASE HAVE THIS COMPLETED WITHIN ONE MONTH OF THE PROCEDURE DATE --***

Dear Medical Doctor,

Thank you so much for your assistance in providing preoperative guidance and clearance! Our patient would like to undergo the following:

_____ Anesthesia: ❑ Monitored ❑ General Duration: _____ hrs / min

Ideally, I would like our patient to hold ASA for 2 weeks, Plavix (and related) for 10 days, Coumadin for 5 days, and other blood thinners as appropriate. For general anesthesia, I require that patients hold metformin for 2 days prior to the procedure. If any of these requirements are problematic, please give me your recommendations. Thank you.

Joseph Walrath, MD

**Exam Date:**

**PATIENT NAME:** _____

**DATE OF BIRTH:** _____

**MEDICATIONS** **DOSE**

**DRUG ALLERGIES:**

**?LATEX ALLERGY: NO❑ YES❑**

**PHYSICIAN COMPLETING FORM:** **OFFICE #:**

**BP:** _____ **HR:** _____ **T:** _____ **RR:** _____ **SaO2:** _____ **Gen. Appearance:** _____

| | Normal | FINDINGS | HISTORY: |
|---|---|---|---|
| SKIN | | | SURGICAL: |
| LYMPHATICS | | | |
| HEENT | | | |
| NECK | | | |
| BREASTS | | | MEDICAL: |
| CHEST/LUNGS | | | |
| HEART RHYTHM | | | |
| HEART MURMUR | | | |
| VASCULAR | | | |
| ABDOMEN | | | |
| EXTREMITIES | | | TOBACCO / ETOH: |
| NEUROLOGICAL | | | FAMILY Hx: |

**Cleared for scheduled surgery: YES ❑ NO ❑**

**M.D. Signature:** _____