Texas Eye Surgery Center

Medical Clearance for Surgery

Patient Name: _____

Date of birth: _____

Physician name: _____

Specialty: _____

Physician Phone / Fax:_____

Does this patient have any medical condition(s) that would preclude eye surgery with IV conscious sedation? ___No ___Yes:

Explain_____

_____

_____

Please list any special precautions necessary before, during, or after surgery:

_____

_____

☑ **I give this patient Medical Clearance for eye surgery**

_____ _____

Physician Printed Name Physician signature

_____

Date

Please fax to Texas Eye Surgery Center at 817-554-0201

Attention: Pre-op Nurse

Click here to submit via email