**MEDICAL CLEARANCE**

Patient: \_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: **Dr.** **Hu / Dr. Cherne** Specialty:\_**Opthalmology**\_\_\_\_\_\_\_\_Phone/Fax:\_**817-282-6392**\_\_\_\_\_\_\_\_

Date of Surgery: \_\_\_\_\_\_\_\_\_\_\_Indications for Medical or Cardiac Clearance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proposed surgical procedure: **Cataract Extraction** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proposed Anesthesia: **Conscious Sedation**  \_\_\_\_\_\_\_\_

**We do not stop anticoagulants.** \_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recommendations for Surgery/Anesthesia: \_\_\_\_\_\_ \_

 \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Required:**

**Patient is cleared for proposed surgical procedure and anesthesia □ Yes □ No**

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**Examining Physician Signature Date/Time**

 **(please print)**

**\*Please return this form and any accompanying documentation to TESC as soon as possible.**

Any questions, call pre-op nurse 817-540-6060 ext. 2122.