TEXAS EYE
SURGERY CENTER

(817) 540-6060 • (817)282-6392-Fax

MEDICAL CLEARANCE

Patient: _____ D.O.B: _____

Physician: **Dr. Hu / Dr. Ranelle** 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:

Required:

Patient is cleared for proposed surgical procedure and anesthesia ◯ Yes ◯ No

_____

Examining Physician (please print) **Signature** **Date/Time**

***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.