EYECARE 20/20

Neil F. Notaroberto, M.D. • Arley G. Jaramillo, M.D.
Lisa R. Pradillo, O.D. • Melissa Freyder Dugan, O.D.
Retinal Disease • Vitreoretinal Surgery • General Ophthalmology • Therapeutic Optometry
www.EyeCare2020.org

DATE: ____

PATIENT'S NAME: _____________________________________

TENATIVE SURGERY DATE: _____________________________

SURGEON: ____

Dear Dr.______________________________

The above named patient is scheduled for surgery. This will be performed with careful monitoring which includes anesthesia and Registered Nurses.

In order to provide this patient with the best possible care during their surgical procedure, please complete the enclosed patient history form, <u>Diagnostic testing is not required unless you feel it medically necessary</u>, If you do perform any blood work or EKG, please provide the results to us.

Please fax this form to our office at least one week prior to the surgery date.

FAX TO: 985-641-2790

If you have any questions, do not hesitate to call us at 504-737-3456. Thank you for your prompt attention to this matter.

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PATIENT HISTORY

PATIENT NAME: ____________________________ AGE: ________

ALLERGIES: ____

EXAMINATION DATE:______________SURGEON:______________________

B/P:______________ PULSE:________ RESP.: ________TEMP.:_________

PAST MEDICAL HISTORY:____

CURRENT MEDICATIONS: ____

GENERAL APPEARNACE: ____

HEART: ____

LUNGS: ____

EXTREMETIES: ____

LAB DATE: ____

HGB: ______________ HCT: ______________PLT: ______________

GLUCOSE: ______________ NA: ______________ K: ______________

BUN: ______________ CR: ______________

SIGNIFICANT OTHERS: ____

EKG: ____

(Please send an interpreted copy if done)

[ ] CLEARED FOR SURGERY VALID FOR ______ WEEKS.

[ ] IS NOT CLEARED DUE TO: _____________________________________

[ ] REFERRED TO ______________________ FOR LAB[ ] EKG [ ]

CLEARED BY:____________________________