EPS Surgical Medical Clearance Form

Medical clearance is needed from your primary care physician **before your date of surgery.**

Your primary care physician should complete the attached form.

Please print a copy and take to your primary care physician's office for them to complete. **We ask that you assist us in ensuring your primary care physician completes this form in a timely manner.** If you are unable to take to their office, please direct them to our website at www.atlantaeye.com, and click on **Surgical Patient Forms**.

Upon completion of the form, please fax to:
Attention: VIP Services
Fax # (404) 294-3353
Alternate Fax # (404) 294-9361

If you have any questions, please contact us via phone at (404) 292-2500.

Charles W. McDowell, MD
Peter A. Gordon, MD
Paul E. McManus, MD
John W. Thomas, MD
Laura A. Bealer, MD
Indira Menon, MD
Christina L. Weeks, MD
Ajeet Dhingra, MD
Shalin Shah, MD

EYE PHYSICIANS & SURGEONS, PC
1457 Scott Blvd – Decatur, GA 30030 Fax: 404-294-3353

MEDICAL CLEARANCE

Dear Dr. _____ Phone: _____ Fax: _____

Dear Dr. _____ Phone: _____ Fax: _____

The patient listed below is scheduled for EYE SURGERY in the near future.
SHOULD YOU CHOOSE TO SEE THIS PAITNET IN YOUR OFFICE TO PROVIDE SURGICAL CLEARANCE, PLEASE HAVE YOUR OFFICE CONTACT THE PATIENT DIRECTLY.
Please fax your evaluation AND any supporting documentation as soon as possible as this information must be obtained by my office in order to proceed with surgery.
**If you have any questions, please call (404) 292-2500, ask for a Surgical Coordinator
If you use EMR or your records are relatively legible, please send with this form.
Simply state if the patient is cleared for surgery, sign and attach your supporting information.

PATIENT'S NAME: _____

PATIENT'S PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ PRE-OP DATE: _____

DIAGNOSIS: _____ SURGERY DATE: _____

PROPOSED SURGERY: _____

ANESTHESIA: _____

Significant past medical history: _____

_____

_____

_____

_____

MUST HAVE CURRENT MEDICATION LIST (INCLUDING DOSAGES) FOR MEDICAL RECONCILIATION_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

List of previous operations: _____

_____

_____

Drug Allergies: _____

_____

_____

BLOOD PRESSURE: _____ PULSE: _____

HEENT: _____

LUNGS: _____

CARD / VASC: _____

ABD _____

EXT _____

NEURO / PSYCH _____

DIAGNOSES _____

REMARKS _____

IS THIS PATIENT CLEARED FOR SURGERY? ☐ YES ☐ NO

DATE: _____ SIGNED: _____, MD