

# MidAmerica

## SURGERY CENTER

Dear Dr. \_\_\_\_\_

Date: \_\_\_\_\_

Your patient \_\_\_\_\_ DOB: \_\_\_\_\_ has been scheduled for eye surgery under TOPICAL anesthesia at the MidAmerica Surgery Center. **The surgery will only be performed if you grant medical clearance.** The outpatient surgery center does NOT require any preoperative laboratory studies. These tests are at your discretion. Please fax this form to the number **(636) 534-5059**. Please return 10 days prior to surgery at the latest. **Call with any questions 636-534-5138** Surgery date \_\_\_\_\_

A comprehensive medical history and physical completed by a physician must be performed **within 30 days** of the date of the scheduled surgery. This is a new Medicare requirement that takes effect on May 18, 2009. Please note we are a Medicare Facility and this is required even if you do not have Medicare.

Date of Exam \_\_\_\_\_

History/Problem List

Allergies \_\_\_\_\_

Physical Exam: BP \_\_\_\_\_ P \_\_\_\_\_ RR \_\_\_\_\_ T \_\_\_\_\_

HEENT \_\_\_\_\_

Heart \_\_\_\_\_

Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_

Extremities \_\_\_\_\_

Neurologic \_\_\_\_\_

Diagnosis \_\_\_\_\_

EKG \_\_\_\_\_

Blood work \_\_\_\_\_

Medications: Please list dosages/frequency

1. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 6. \_\_\_\_\_

3. \_\_\_\_\_ 7. \_\_\_\_\_

4. \_\_\_\_\_ 8. \_\_\_\_\_

This patient has been cleared for eye surgery under topical anesthesia.

Signature: \_\_\_\_\_