

## 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](http://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.

**EYE PHYSICIANS & SURGEONS, PC**

1457 Scott Blvd Decatur, GA 30030 Phone: 404-292-2500 Fax: 404-267-6709

Pre-op Evaluation**Charles W. McDowell, Jr, MD** TO DR. \_\_\_\_\_ Voice # \_\_\_\_\_ Fax # \_\_\_\_\_**Peter A. Gordon, MD**

\_\_\_\_\_ Voice # \_\_\_\_\_ Fax # \_\_\_\_\_

**Paul McManus, MD****John Thomas, MD****Laura Bealer, MD****Indira Menon, MD****Ajeet Dhingra, MD****Christina Weeks, MD**

This patient is scheduled for eye surgery in the near future. Should you choose to see this patient in your office to provide surgical clearance, please ask your office personnel to contact the patient directly. Please fax your evaluation and any supporting documentation as soon as completed.

Thank you! Your assistance is greatly appreciated!

PATIENT'S NAME \_\_\_\_\_

PATIENT'S PHONE (HOME) \_\_\_\_\_ (CELL) \_\_\_\_\_

x  
BIRTHDATE \_\_\_\_\_ PRE-OP DATE \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_ SURGERY DATE \_\_\_\_\_

PROPOSED SURGERY \_\_\_\_\_ ANESTHESIA \_\_\_\_\_

CC: \_\_\_\_\_

CC: \_\_\_\_\_

Significant past medical history:

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

List of previous operations:

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

Current Medications with Dosages:

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

Drug &amp; Food Allergies:

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

B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_

HEENT \_\_\_\_\_

LUNGS \_\_\_\_\_

CARD/VASC \_\_\_\_\_

ABD \_\_\_\_\_

EXT \_\_\_\_\_

NEURO/PSYCH \_\_\_\_\_

DIAGNOSES \_\_\_\_\_

Remarks: \_\_\_\_\_

Is this patient cleared to have surgery? \_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_, M.D.