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DIAGNOSTIC EYE CENTER

Aric R. Welton, O.D.
Therapeutic Optometrist

Stephanie M. Lozano, O.D.
Therapeutic Optometrist

Dear Doctor,

Diagnostic Eye Center is committed to the highest quality of patient care and safety during surgical procedures and is requesting the following information from your office. We greatly appreciate your attention and prompt response to this form.

Patient Name: _____ DOB: _____

Procedure: _____ Date of Surgery: _____

Anesthesia: Topical / Retrobulbar / Mac / General

Physician Name: _____ Specialty: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

Patient's Diagnosis & Severity: _____

Current Medication(s) (Frequency & Dosage): _____

Does the patient have any medical condition(s) that would preclude cataract eye surgery in an ambulatory surgical center under IV conscious sedation supplemented with local anesthesia?

____ Yes ____ No Comments: _____

Please list any special precautions necessary before, during, and after the procedure. (BP, pulse, and O2 saturation will be monitored by a certified nurse anesthetist / anesthesiologist during the procedure.)

Is the patient cleared for surgery? Yes / No

(Please include a copy of the patient's most recent EKG and blood work.)

Other comments: _____

Physician's Signature: _____ Date: _____