DIAGNOSTIC
EYE CENTER

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): _________________________________

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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: ____

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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.)

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Is the patient cleared for surgery? Yes / No

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

Other comments: ____

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Physician's Signature: _______________________________ Date: _________________