_____CATARACT and LASER CENTER, LLC_____

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Carl Park, MD (NPI 1942274535)

To our patient*:** ***Please give this letter and history and physical form (on the reverse side) to your primary care physician so they may clear you for your surgery. We recommend you request a copy for your records.

Patient Name:____

Surgical Procedure:

- ☐ Cataract
- ☐ Laser Treatment for:
  - Secondary Membrane   Glaucoma   Retinal
- ☐ Other:____

Date of Procedure:__________________________

Our mutual patient will be undergoing the above referenced surgical procedure at the Cataract and Laser Center. Guidelines state that all surgical patients are required to have a **history and physical** form completed from their medical doctor no more than 30 days prior to the procedure.

Due to the nature of the surgery, we do not require an EKG or blood work.

If your office uses electronic health records you may send the clearance in your own format, but your plan needs to state that the patient is cleared for surgery in an ambulatory setting using topical and/or local anesthesia; or you may sign and send this cover letter along with your evaluation.

We ask that you fax the completed form to **302-454-1329** no less than two (2) working days prior to the date of surgery.

The above referenced patient is cleared for surgery in an ambulatory setting using topical and/or local anesthesia.

Signed:___________________________________MD, DO, NP, PA Date:_________________

If you have any questions, you may contact a member of our nursing staff at 302-454-8802.

Cataract and Laser Center, LLC History and Physical Examination

Please fax completed form to 302-454-1329

Patient Name: ______________________________ **Date of Birth:** ______________

ALLERGIES: ☐ **No Known Drug Allergies** ______________________ Latex Allergy: Yes / No

MEDICATIONS/DOSAGES: Attached List: ☐ ______________________________

Blood Thinner: *Yes* *No* *Aspirin:* *Yes* *No* *Alpha Blocker:* *Yes* *No*

MEDICAL HISTORY : ______________________________

SURGICAL HISTORY: ______________________________

SOCIAL HISTORY: Smoker: Yes No ETOH Use: Yes No Drug Use: Yes No

IF NO SIGNIFICANT FINDINGS, CHECK BOX. **DESCRIBE ABNORMAL FINDINGS**

- ☐ CONSTITUTIONAL ______________________________
- ☐ HEAD/NEUROLOGICAL ______________________________
- ☐ EENT ______________________________
- ☐ CARDIOVASCULAR ______________________________
- ☐ RESPIRATORY ______________________________
- ☐ GASTROINTESTINAL ______________________________
- ☐ GENITOURINARY ______________________________
- ☐ MUSCULOSKELETAL ______________________________
- ☐ ENDOCRINE ______________________________
- ☐ HEMATOLOGIC ______________________________

PHYSICAL EXAM: BP: ______________ R / L P: ____________ R: ____________ T: ____________

Head/Neuro:		Resp:	
Neck:		Skin:	
CV:		M/S:	

Diagnosis:

☐ **Patient is cleared for surgery in an ambulatory setting.** ☐ **Patient is cleared for topical and/or local anesthesia.**

Signature: ______________________________ MD/DO/NP/PA Date: ______________

Printed Name: ______________________________ Phone #: ______________