CATARACT & LASER CENTER LLC

Jeffrey Boyd, MD (NPI 1255498366)
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 provider so that they may clear you for your surgery. We recommend that you request a copy for your records.**

Patient Name: _____ Date of Birth: _____

Procedure Date(s): _____

Surgical Procedure:

☐ Cataract ☐ Glaucoma ☐ Other _____

☐ Laser Treatment for: ☐ Secondary Membrane ☐ Glaucoma ☐ Retinal Procedure

☐ Other: _____

Our mutual patient will be undergoing the above referenced surgical procedure at the Cataract and Laser Center. Delaware Regulations for Free Standing Surgical Centers, 16 Del. C. §122 (3)(p), require all surgical patients to have a completed history and physical from their medical provider no more than 30 days prior to the procedure.

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

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 mild, topical and local anesthesia**; or you may sign and send this cover letter along with your evaluation.

We ask that you fax the requested documentation to (302) 454-1329 no less than two (2) business days prior to the date of surgery. Failure to return this form may cause the patient's surgery to be delayed or cancelled.

PLEASE COMPLETE ATTACHED HISTORY & PHYSICAL FORM

Cataract and Laser Center, LLC History and Physical Examination Form
Please Fax Completed Document to (302) 454-1329

Chief Complaint: ☐ Cataract Surgery with minimal sedation ☐ Laser Retinal Procedure
☐ Laser Glaucoma Procedure ☐ Laser Posterior Opacification Procedure
☐ OD (Right Eye) ☐ OS (Left Eye) ☐ OU (Both Eyes)

Allergies: ☐ **NKDA:**_____
_____
_____

Current Medication Orders ☐ **See Attached List:** _____
_____
_____
_____

Medical History: _____
_____
_____
_____

Surgical History: _____
_____
_____
_____

Psychosocial Assessment: ☐ Tobacco/Tobacco Products/Vape Use ☐ Alcohol Use ☐ Recreational Drug Use

Physical Assessment

Vital Signs: BP _____ **P** _____ **R** _____ **Temp** _____ **Pulse Ox** _____

WNL	System	Description of Abnormal Findings
	Constitutional	
	Head and Neck	
	Cardiovascular	
	Respiratory	
	Gastrointestinal	
	Genitourinary	
	Extremities	
	Neurological	
	Endocrine	
	Hematologic	

☐ **Patient is Clear For:** ☐ **Cataract Surgery** ☐ **Laser Procedure**
☐ **Patient is Clear for Minimal Sedation**
☐ **Patient is Clear for Topical and Local Anesthesia**

Provider Name (print): _____ **MD/DO/PA/NP Date:** _____

Provider Signature: _____ **MD/DO/PA/NP Date:** _____

Patient Name: _____ **Date of Birth:** _____