

Pre-Op Clearance for LAUREL LASER & SURGERY CENTER --FAX TO 814-949-8940

Surgeon: Parag Parekh, MD Tel: 814-372-2389 Secure Email: pdp@clearview.emadirect.md	PCP Info: Name: _____ Date of Surgery: _____ <u><i>We suggest the PCP Visit to be between:</i></u>
Patient Name: _____	
Planned Surgery: Cataract Extraction with Insertion of Intraocular Lens For: Decrease Vision	

ALLERGIES/REACTIONS:

MEDICATION LIST with Dosage:

PAST MEDICAL HISTORY

- Active Infectious Disease: _____
- Inactive/Colonized Infectious Disease: _____
- Problem List:

PAST SURGICAL HISTORY:

Relevant Family Hx: _____ **Relevant Social Hx:** _____

SYSTEMS REVIEW:

HEENT: _____ CNS: _____ Cardiac: _____ Pulmonary: _____
 Musculoskeletal: _____ GI: _____ GU: _____ GYN: _____

PHYSICAL EXAM:

Mental Status: _____ HR: _____ BP: _____ HT: _____ WT: _____
 HEENT: _____ Neck: _____
 Heart: _____ Lungs: _____
 Abdomen: _____ Extremities: _____

IMPRESSION:

Patient is an acceptable surgical risk with MAC in an Ambulatory Surg. Ctr. _____

Physician Signature and Date

**Any PA-C must have an MD/DO co-signature on form.
 Please fill out form in its entirety and attach H&P.**