MEDICAL CLEARANCE REQUEST

Dear Doctor,

LaserVue 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: ______/_______/_______

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 surgery 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, O2 Saturation will be monitored by a certified nurse anesthetist / anesthesiologist during the procedure).

____

____

Other Comments:

____

____

Surgery Date: _______/_______/_______

Physician's Signature: ______________________________ Date: _______/_______/_______

Dr. Jay Bansal can be reached at (707) 522-6200 for any further questions.
Please fax completed form to (707) 522-6215.