REQUEST FOR MEDICAL CLEARANCE

Please sign and Fax with requested test results to: (619)215-0404

Kimberly P. Cockerham, MD

(Neuro-Ophthalmology, Eyelid/Orbital Oncology, Oculofacial Reconstruction)

Senta Clinic

3590 Camino Del Rio North, Suite 200

San Diego, CA 92108

Physician Name:______________________________

Office Number:____________________ Fax Number:______________________

Patient Name:____________________________ DOB: _____/_____/_____

Surgery Date: _____/_____/_____

Anesthesia: Local with Mac___ General______

DIAGNOSIS:

____

PROCEDURE:

____

*Pre-operative medical clearance is required prior to surgery. Please INCLUDE and attach: labs < 90 days old -and- EKG < 30 days old:

1.On Blood Thinners? 2. EKG (Only if Cardiac clearance needed) 3.CBC/Chem Panel

**If patient is currently taking a blood thinner, PLEASE list below, notate, and advise patient how many days prior to surgery to stop and once surgery is performed when it can be resumed. If patient is not on a blood thinner, please indicate so below.

____

____

*EKG *CBC & CHEM PANEL

*PACEMAKER YES____ NO___ *DEFRIBILLATOR YES___ NO___

______Patient is cleared for surgery as noted above.

______Patient is NOT cleared for surgery due to:

____

______________________ ______________________

Signature of Physician Date of Signature