## American Eye Surgery Center Medical Clearance Form

Dear Doctor,

We greatly appreciate your attention to this form. Dr. Dong or Dr. Tuckfield can be reached if necessary, at 1-800-287-2519 or (706) 546-9290. The American Eye Surgery Center is deeply committed to the highest quality of patient care and safety during surgical procedures. Our center is fully Medicare approved and AAAHC accredited.

Please fax back to (706) 354-4074; by noon 1 week before scheduled surgery.

Patient Name:		DOB:
Phone:		Fax:
Day of Surgery:		Cataract Surgery with IOL Blepharoplasty Other:
Medical History:		
Previous Surgeries:		
Allergies/Sensitivities: _		
Current Medications:		
Anti PHYSICAL EXAMINA		aract surgery***
BP:		O2 sat:
Height: Heart:	Weight:	
Head & Neck:	Lungs:Other Perti	nent Findings:
center with IV c		urgery in our ambulatory surgery nented with local anesthesia? NO
Comments:		
Signature of Medical Provider		Date
Print Name of Medical Provider		