

# CARDIAC CLEARANCE REQUEST

Date: \_\_\_\_\_/\_\_\_\_\_, 20\_\_ \_\_

Dear Dr. \_\_\_\_\_  
Cardiologist

Re: Our mutual patient: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

The patient is or will be, scheduled for surgery on \_\_\_\_\_, 20\_\_ \_\_

Requiring a  MAC or  General anesthetic.

Length of Procedure: \_\_\_\_\_ Hours \_\_\_\_\_  Minutes

We are requesting Cardiac Clearance for:

Procedure:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Patient needs the following prior to risk stratification:

\_\_\_\_\_  
\_\_\_\_\_

Patient is ***at low risk*** for surgery from a cardiac standpoint.

Patient is at ***increased*** risk but not prohibitive risk from a cardiac standpoint. To minimize risk, we recommend the following:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Patient is at ***prohibitive*** risk from a cardiac standpoint for the above procedure.

Patient  May  May Not stop Plavix/ASA \_\_\_\_\_ days before procedure.  
Patient  May  May Not stop Coumadin \_\_\_\_\_ days before procedure.  
Patient may restart Coumadin/Plavix/ASA \_\_\_\_\_ days post procedure.

\_\_\_\_\_  
**Cardiologist Signature** ( ) \_\_\_\_\_  
**Telephone Number**

\_\_\_\_\_, 20\_\_ \_\_  
**Date**

**PLEASE FAX COMPLETED FORM ASAP TO COMMUNITY SURGERY CENTER  
NORTHWEST @ (317) 621-3016. ANY QUESTIONS PLEASE CALL (317) 621-3010.**