

## VASCULAR CLEARANCE REQUEST

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

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

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 Vascular Clearance for:

Procedure:

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

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

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

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

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

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

Patient is at *prohibitive* risk from a vascular 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.

\_\_\_\_\_  
\_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

**Physician 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.**