ColumbiaDoctors | Ophthalmology

NewYork-Presbyterian
Columbia University Medical Center
Edward S. Harkness Eye Institute

ColumbiaDoctors Ophthalmology
Surgical Scheduling Office
Telephone: (212) 305-3069 Fax: (212) 342-5435

Pre-Surgical Medical Clearance with your Medical Doctor

Patient Name: _____ **DOB:** _____
Surgeon: _____ **Surgery Date:** _____
Procedure: _____ **Length of Procedure:** _____
_____

Type of Anesthesia: ☐ **MAC** ☐ **General**

You must obtain medical clearance from the physician who manages your medical care (usually your primary care provider) within 30 days of your scheduled surgery date. The physician must complete a full **History & Physical Clearance Form** (see attached).

If you are 60 years of age or older, you are required to have an electrocardiogram (EKG):

- **MAC (Monitored Anesthesia Care):** EKG within **1 year** of your scheduled surgery date
- **General Anesthesia:** EKG within **30 days** of your scheduled surgery date

Please Note: If you have other medical issues, additional testing may be required (labs, chest x-ray etc.) at the discretion of the doctor providing medical clearance in order to medically clear you for surgery.

All results should be faxed to (212) 342-5435 or otherwise presented to the surgical scheduling office with delivery at least 7 business days prior to your surgery date.

Please call us at (212) 305-3069 should you have any questions.

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

☐ SDS
☐ AS

50173

PERIOPERATIVE SERVICES / HISTORY & PHYSICAL DAY OF SURGERY ORDERS

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Date: _____/_____/_____ **Time:** _____ AM/PM

SUBMIT THIS DOCUMENTATION AND ALL TEST RESULTS TO THE PRESURGICAL DOCUMENTATION CENTER NO LATER THAN 2 DAYS PRIOR TO THE DATE OF SURGERY

PATIENT NAME:	ADMISSION DIAGNOSIS: (1)
HISTORY NUMBER: (UNCONFIRMED) AGE: DOB:	SECONDARY DIAGNOSIS: (2)
FATHER'S FULL NAME:	PROCEDURE/OPERATION:
REFERRING PHYSICIAN NAME:	PROCEDURE DATE: _____/_____/_____ CONFIRMATION #:
GOING TO PAT ☐ YES ☐ NO PREADMISSION TESTING DATE: _____/_____/_____ PAT AT NYPH? ☐ YES ☐ NO Where _____	PRINT SURGEON NAME/ID CODE:

HISTORY AND PHYSICAL

HISTORY OF PRESENT ILLNESS (HPI):
Specific Surgical in PI: Narrative HPI

HISTORY:

Past Surgical History:

Surgery	Date
	/ /
	/ /
	/ /
	/ /

Past Medical History:

Condition	Date
	/ /
	/ /
	/ /
	/ /

Medications: List of Medications (including over -the-counter medications): (Complete Medication Reconciliation form - 51187)

Medications	Dosage	Frequency

Family History: ☐ Heart Attack ☐ Cancer ☐ Colon Problems ☐ Other _____ ☐ None

Do you have allergies? Yes No FOOD DRUG LATEX OTHER _____

ALLERGEN	REACTION

50173 (9/11)

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REVIEW OF SYSTEMS:

	Normal	Abnormal	Describe Abnormal findings
Constitution	☐	☐	☐ Fever ☐ Weight loss ☐ Other _____
Cardiovascular	☐	☐	☐ Heart attack ☐ Chest pain ☐ Mitral valve prolapse ☐ Hypertension ☐ Claudication ☐ Other _____
Respiratory	☐	☐	☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Cough ☐ SOB ☐ Other ___
Gastrointestinal	☐	☐	☐ GERD ☐ Peptic Ulcer disease ☐ Diverticulitis ☐ Irritable bowel ☐ Hepatitis ☐ Cirrhosis ☐ Hypercholesteremia ☐ Gall Bladder disease ☐ Other _____
Genitourinary	☐	☐	☐ Renal Failure ☐ Other _____
Musculoskeletal	☐	☐	☐ Rheumatoid arthritis ☐ Other _____
Neurologic	☐	☐	☐ Stroke ☐ Other _____
Psychiatric	☐	☐	☐ Depression ☐ Anxiety ☐ Bipolar ☐ Other _____
Endocrine/Metabolic	☐	☐	☐ Diabetes ☐ Lupus ☐ Thyroid disease ☐ Other _____
Hematologic/Lymphatic	☐	☐	☐ Anemia ☐ Other _____
Substance Abuse	☐ No	☐ Yes	substance _____ last used : ____/____/____
Smoking	☐ No	☐ Yes	when quit : ____/____/____ ppd: _____
Cancer	☐ No	☐ Yes	_____
Other	☐	☐	_____

PHYSICAL EXAM: (check all that apply)

CONSTITUTIONAL:

VS: Temp _____°C Pulse _____ Respiration _____ BP _____ Height _____(cm) Weight _____(kg)

General Appearance ☐ Normal ☐ Malnourished ☐ Overweight ☐ Obese ☐ Morbidly obese

EYES

Inspection of conjunctiva, lids: ☐ Normal ☐ Icteric conjunctiva ☐ periorbital edema ☐ abnormal sclerae ☐ Other _____

Examination of pupils/iris: ☐ PERRLA ☐ Other: _____

NECK

Overall appearance: ☐ Normal **Masses:** ☐ None ☐ Lymph nodes _____ ☐ JVD ☐ Other: _____

Thyroid: ☐ Normal ☐ Other: _____

RESPIRATORY

Effort: ☐ Normal ☐ Tachypneic ☐ Use of accessory muscles ☐ Other: _____

Lungs (Auscultation): ☐ Normal ☐ Other _____

CARDIOVASCULAR

Auscultation of Heart: ☐ Normal ☐ Murmur ☐ Other _____

Examination of Extremities: ☐ Normal ☐ Venous insufficiency ☐ Varicose veins ☐ Edema ☐ Other _____

GASTROINTESTINAL

Examination of Abdomen: ☐ Normal ☐ Masses _____ ☐ Tenderness _____

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MUSCULOSKELETAL:
Examination of Gait and Station: ☐ Normal ☐ Abnormal _____
Assessment of Strength and Tone: ☐ Normal ☐ Atrophy _____ Tremor _____ ☐ Other _____

SKIN
Inspection: ☐ Normal ☐ Erythema ☐ Stasis dermatitis ☐ Jaundice ☐ Ulcer _____
☐ Other _____
Palpation: ☐ Normal ☐ Induration ☐ subq nodules ☐ Other _____

NEUROLOGICAL/PSYCHIATRIC
Orientation: ☐ Normal ☐ Other _____
Mood: ☐ Normal ☐ Other _____

DIAGNOSIS:

PLAN FOR SURGERY:

INFECTION PRIOR TO ANESTHESIA/PRINCIPAL PROCEDURE/SURGERY START TIME

☐ Yes, Preoperative Infection exists
☐ Yes, Suspected / Possible Preoperative Infection exists
☐ No

JUSTIFICATION / REASON FOR VANCOMYCIN USE: (check all that apply)

☐ Beta-lactam (penicillin or cephalosporin) allergy
☐ High-risk due to acute inpatient hospitalization within the last year
☐ High-risk due to nursing home or extended care facility setting within the last year, prior to admission
☐ Inpatient stay more than 24 hours prior to the principal procedure
☐ Transferred from another inpatient hospitalization after a 3-day stay
☐ MRSA colonization or infection
☐ Chronic wound care or dialysis
☐ Increase MRSA rate, either facility-wide or operation-specific
☐ Undergoing valve surgery
☐ Not Applicable

Signature: _____ MD/PA/NP Date: ____/____/____ Time: _____ AM/PM

Print Name: _____ ID CODE # _____

Reviewed by Attending Surgeon: _____ MD Date: ____/____/____ Time: _____ AM/PM

Print Name: _____ ID CODE # _____