OPHTHALMIC CONSULTANTS OF BOSTON
EXCELLENCE IN EYE CARE
www.eyeboston.com
800-635-0489

Founding Partners
Albert R Frederick, Jr, MD
B Thomas Hutchinson, MD
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Dear Doctor:

Your patient ______________________________ DOB ______________________

Has been scheduled for the following surgical procedure(s): ______________________

At Boston Eye Surgery and Laser Center on: ____

Please fax the results of this evaluation to our office by __________________________ (date) to 617-573-1065.

In accordance with Medicare and the surgery center's accreditation body, the **Pre-operative Medical Evaluation** form (found on the back, or attached to this sheet) must be performed and completed **within 30 days of the above listed surgical date**.

Surgical Clearance Requirements:

1. Medical clearance exam **WITHIN 30 DAYS of the date of surgery.**
2. An **EKG** with interpretation within 180 days of their surgical date for patients **65 and older or with a cardiac history**
3. Patients will be instructed by the surgery center to discontinue all diuretics the morning of surgery (to resume after surgery); and
4. A **Medical Clearance Statement**. If not medically cleared, please comment.

Not Required:

1. Labs, unless required by surgery center anesthesia staff; and
2. Anticoagulants do not need to be held unless you, as their PCP, feel this is medically necessary.

If your patient requires additional ophthalmic surgery within 180 days of the initial History & Physical (H&P), the surgery center's Anesthesiologist will conduct a Subsequent Surgery Review on the day of surgery. If you feel this patient requires a new H&P performed by you, please indicate this requirement on the initial H&P form. Additionally, if the patient enters the hospital at any point after the initial H&P, a new H&P will be required.

I appreciate your medical consultative support. Please feel free to contact me if you have any questions or information you would like to share with me. With your assistance, I will make the patient's operations as safe and pleasant as possible.

Thank you,

Peter A. Rapoza, M.D.
Ophthalmic Consultants of Boston
50 Staniford Street
Boston, MA 02114
Phone: 617-314-2660
Fax: 617-573-1065

Glaucoma, Cataract and Surgery of the Anterior Segment
Claudia U Richter, MD
Bradford J Shingleton, MD
Michael F Oats, MD
Laura C Fine, MD
James W Hung, MD
Bonnie An Henderson, MD
Stephen H Rostler, MD
Tom C Hsu, MD
Husam Ansari, MD, PhD
Edward M Barnett, MD, PhD
Joshua J Ney, MD
Daniel J O'Connor, MD
Retina, Vitreous and Macula
Trexler M Topping, MD
Michael G Morley, MD, MHCM
Jeffrey S Heier, MD
Tina S Cleary, MD
Torsten W Wiegand, MD, PhD
Chirag P Shah, MD, MPH
Cornea, Cataract and Surgery of the Anterior Segment
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Michael B Raizman, MD
Nicoletta Fynn-Thompson, MD
Peter A Rapoza, MD
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Ophthalmic Plastic, Lacrimal and Orbital Surgery
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Claudine Y Kawabata, OD
Anne J Farley, OD
Stephen M Taylor, OD
Kristy B Wooler, OD
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Benjamin I Graham, OD
Holly P Schneider, OD
Kit T Ip, OD
Dannielle F Richard, OD
Yang Yang, OD
Jami B Parsons, OD
Dana M Bastarache, OD
Roger A Bush, OD
David G Milliken, OD

PRE-OPERATIVE MEDICAL EVALUATION

☐ Boston: 50 STANIFORD STREET, BOSTON, MA 02114
☐ Waltham: 52 SECOND AVE, WALTHAM, MA 02451

FAX TO: 617-573-1065

Patient: ______________________

DOB: ______________________

Surgery Date: ______________________

Surgeon: Peter A. Rapoza, M.D.

SURGICAL CLEARANCE REQUIREMENTS:

Please see Surgical Clearance Requirements 1-4 on the back side of this form.

DIAGNOSIS/HISTORY OF PRESENT PROBLEM:

PAST HISTORY	NEG	IF POSITIVE- LIST COMMENTS
CARDIAC: Infarction, failure, murmur, arrhythmia palpitations, hypertension, angina	☐	
PULMONARY: Bronchitis, emphysema, asthma pneumonia, sputum, TB	☐	
CNS: Seizures, stroke, migraine, MS	☐	
KIDNEY: Infections, failure	☐	
ENDOCRINE: Diabetes, thyroid, adrenal	☐	
LIVER: Hepatitis, failure	☐	
FAMILY HISTORY OF BLEEDING TENDENCY:	☐	
PAST SURGERY:	☐	

DRUGS TAKEN IN THE PAST SIX MONTHS	NEG	OR	DRUG	DOSE	DISCONTINUED
CARDIAC: Diuretics, antihypertensive beta blockers, digitalis	☐				
PULMONARY: Bronchodilators	☐				
CNS: Anticonvulsants, tranquilizers	☐				
ENDOCRINE: Insulin, steroids, thyroid	☐				
BONE/JOINT: Anti-inflammatory	☐				
EYE: Eye drops	☐				
ALCOHOL/DRUG ABUSE:	☐				
FLOMAX:	☐				

DRUG ALLERGY/ SENSITIVITY	NEG	OR	DRUG	TYPE OF REACTION
	☐			

PHYSICAL EXAMINATION:	NEG
NEUROLOGICAL	☐
HEENT:	
- Ears, Nose	☐
- Mouth, throat	☐
- Neck	☐
CHEST:	
- Respiratory	☐
- Heart	☐
- Breasts	☐
ABDOMEN:	☐

BP	PULSE (reg/irreg)

THE ABOVE NAMED PATIENT IS CLEARED FOR SURGERY: Yes ☐ No ☐

COMMENTS:

PHYSICIAN SIGNATURE: ______________________ DATE: ____________

PRINTED PHYSICIAN NAME: ______________________

☐ IF PATIENT'S SUBSEQUENT SURGERY IS SCHEDULED WITHIN 180 DAYS FROM THIS H&P, THIS PATIENT CAN HAVE A MEDICAL EVALUATION BY THE SURGERY CENTER'S ANESTHESIA STAFF FOR PRE-SURGICAL CLEARANCE.

☐ IF PATIENT'S SUBSEQUENT SURGERY IS SCHEDULED WITHIN 180 DAYS FROM THIS H&P, THIS PATIENT WILL BE REQUIRED TO SEE ME FOR PRE-SURGICAL CLEARANCE.