Champion Eyecare
6817 Southpoint Pkwy. Suite 1503
Jacksonville, FL. 32216
P: 904-903-4068
FAX: 904-900-5347

Dear Primary Care Provider,

Thank you for partnering with us in ensuring that our patients enjoy a successful and uneventful ambulatory surgery.

EVALUATION:

Please complete included form in its entirety. Notes from an office visit are acceptable, as long as all necessary details are included (i.e., **surgical history, medical history, allergies, medications, social history, family history, ROS, and physical exam**). Labs, EKG, chest x-ray or additional ancillary tests are NOT necessary, unless designated otherwise for an individual patient, or PCP feels they are needed to determine medical optimization.

NECESSARY REFFERALS:

If, during the preoperative examination, a previously stable or well-controlled condition is noted to be worsening, it is expected that the PCP will refer that patient to the appropriate specialist (cardiology, pulmonology, nephrology, etc) for evaluation.

EXCLUSION CRITERIA:

Patients with the following conditions (**ASA IV or higher**) are **NOT** candidates for ambulatory surgery:

- Recent (within the last 3 months) MI, CVA, TIA, cardiac stent, cardiac intervention or pending cardiac intervention
- Uncontrolled/refractory to medication HTN (>180/110, while on medication)
- Ongoing cardiac ischemia or severe valve dysfunction (primarily severe aortic stenosis)
- Severe reduction of cardiac ejection fraction (EF< 30%)
- Severe COPD
- Sepsis
- End Stage Renal Disease (ESRD) NOT undergoing regularly scheduled dialysis
- Severe, uncontrolled Diabetes presenting on the day of surgery with finger stick blood glucose of >300mg/dL or HbA1C >12
- Patients whose weight is greater than 350 lbs. must be evaluated by an Anesthesia Care Provider preoperatively.

Note: BMI >45 must be evaluated and approved by an Anesthesia Care Provider preoperatively

If you have any questions at all, please do not hesitate to contact us

PATIENT HISTORY & PHYSICAL FOR SURGERY

PLEASE FAX BACK COMPLETED TO: 904-900-5347

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

MEDICAL HISTORY

SURGICAL:

MEDICAL:

ALLERGIES:

MEDICATIONS:

FAMILY HISTORY:

SOCIAL HISTORY:

REVIEW OF SYSTEMS: [NEGATIVE] [POSITIVE] for _____

PHYSICAL EXAMINATION

TEMP:	BP:	HR:	RESP:	SA O2%:	HT:	WT:	SEX: [M] [F]

** ADDRESS EACH BOX AS APPROPRIATE	COMMENTS
☐ **GENERAL APPEARANCE:** WNWD, NAD	
☐ **H.E.E.N.T:** NCAT/EOM/PERRL/NL Mucosa	
☐ **HEART:** RRR/ No M, R, G	
☐ **LUNGS:** Clear Bilaterally	
☐ **ABDOMEN:** Normal BS, No Distension/Tympany, Non tender, No masses, No guarding	
☐ **NERVOUS SYSTEM:** CN II – CN XII Grossly intact	
☐ **MUSCULOSKELETAL:** No significant deformity	
☐ **PSYCHOLOGICAL:** Alert & Oriented x 3	
☐ **BREAST/PELVIC/RECTAL:** (Deferred)	

☒ (N/A) LABS, XRAY:

IMPRESSION:

PLAN:

COMMENTS:

☐ The patient is cleared for surgery in an ambulatory setting

PRINT PHYSICIAN'S NAME:	**DATE:**
PHYSICIAN'S SIGNATURE	**DATE:**

LABEL

NAME: _____

DOB: _____