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**MEDICAL CLEARANCE**

Please evaluate patient for surgery with particular attention to cardio-vascular system and reactive airway disease.

For facial surgery, we request a tightly controlled blood pressure - preferably NO GREATER THAN 130 mm Hg SYSTOLIC. This will allow safe use of a "hypotensive" anesthetic technique and minimize peri-operative bleeding.

We administer local anesthetics with epinephrine and IV sedation which includes, but is not limited to drugs, such as ketamine, propofol, versed and narcotics.

If this patient is taking any anticoagulants, aspirin, or monoamine oxidase inhibitors, please note in the remarks section and indicate if these medications can be safely discontinued for 14 days prior to surgery and not resumed until the 4th day post-op.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ EXAM DATE: \_\_\_\_\_

PAST HISTORY, FAMILY HISTORY, AND REVIEW OF SYMPTOMS:

ALLERGIES & SENSITIVITIES:

CURRENT MEDICATIONS:

**PHYSICAL EXAMINATION**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_

TEMP \_\_\_\_\_ RESP \_\_\_\_\_ LUNGS \_\_\_\_\_

EKG REQUESTED  YES  NO

EKG INTERPRETATION \_\_\_\_\_

IF EKG INDICATED PLEASE ATTACH COPY EKG ATTACHED?  YES  N/A

ADDITIONAL TEST(S) REQUIRED: \_\_\_\_\_

COMMENTS:

IS PATIENT CLEARED FOR SURGERY?

YES  NO

**PLEASE PRINT OR ATTACH CARD**

PHYSICIAN'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

Austin-Weston Center  
Doctor \_\_\_\_\_ Date \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_