EPS Surgical Center, LLC
Eye Physicians & Surgeons, PC
Pre-Anesthesia Assessment

Please complete the attached form and make sure you bring with you to your pre-op appointment.

It is very important that you answer all the questions to the best of your knowledge.

It is important that we are made aware of allergies to any medications and to latex, iodine, adhesives and foods.

All medications that you take on a regular basis, including any over the counter medications and vitamins must be listed on the form with the dosage (such as 500 mg) and how often you take them (such as once per day).

If you have any questions, please call us at (404) 292-2500.

EPS SURGICAL CENTER, LLC

PRE-ANESTHESIA NURSING ASSESSMENT

DATE: _____

Patient Name: _____

Weight: _____ Height: _____ Age: _____

Surgeon: _____

Have you traveled outside of the United States in the last 30 days or had contact with anyone who has traveled of the US in the last 30 days? □ YES □ NO If yes, where did you travel? _____

Who is your regular M.D.? _____ When was your last visit? _____

Is this your first-time having anesthesia? □ YES □ NO

Have you or an immediate family member had any problems with anesthesia in the past? □ YES □ NO

Explain: _____

Are you allergic to latex? □ YES □ NO If yes, what is your reaction? _____

Are you allergic to iodine? □ YES □ NO If yes, what is your reaction? _____

Are you allergic to adhesive? □ YES □ NO If yes, what is your reaction? _____

Are you allergic to any foods? □ YES □ NO If yes, what food? _____

What was your reaction to the food? _____

Are you allergic to any medications? □ YES □ NO

If yes, please list the medication and the reaction in the spaces below.

MEDICATION ALLERGY	REACTION TO MEDICATION

Do you take any of the GLP-1/ Semaglutide Medications? If YES, please use the checkbox and indicate the DAY OF THE WEEK.

Most Common GLP-1 agonists:

❒ NO ❒YES Dulaglutide (Trulicity)- weekly _____

❒ NO ❒YES Exenatide (Byetta)- twice daily _____

❒ NO ❒YES Exenatide Extended Release (Bydureon BCise) _____

❒ NO ❒YES Liraglutide (Victoza, Saxenda, Xultophy)- daily _____

❒ NO ❒YES Lixisenatide (Adlyxin) – daily _____

❒ NO ❒YES Semaglutide (Ozempic) -weekly _____

❒ NO ❒YES Semaglutide (Rybelsus), oral-daily _____

❒ NO ❒YES Semaglutide (Wegovy) -weekly _____

❒ NO ❒YES Tirzepatide (Mounjaro) -Weekly _____

Most Common SGLT2 inhibitors:

❒ NO ❒YES Canagliflozin (Invokana)

❒ NO ❒YES Dapagliflozin (Farxiga)

❒ NO ❒YES Empagliflozin (Jardiance)

❒ NO ❒YES Empaglifplozin /linagliptin (Glyxambi)

❒ NO ❒YES Canagliflozin /metformain (Invokamet, Invokamet XR)

❒ NO ❒YES Dapagliflozin/saxagliptin (Qtern)

❒ NO ❒YES Empagliflozin/metformin (Synjardy)

❒ NO ❒YES Empagliflozin /linagliptin/metformin (Trijardy XR)

❒ NO ❒YES Dapagliflozin/metformin (Xigduo)

❒ NO ❒YES Ertugliflozin (Stegltro)

❒ NO ❒YES Ertugliflozin/metformin (Segltromet)

❒ NO ❒YES Ertugliflozin/sitagliptin (Strglujan)

Do you have or have you ever had any of the following:

□ HEART DISEASE	□ MUSCLE WEAKNESS	□ NOSE SURGERY	□ DIABETIC
□ LUNG DISEASE	□ CHEST PAIN	□ BLOOD TRANSFUSION	□ BOWEL/COLON DISEASE
□ HIGH BLOOD PRESSURE	□ BACK/NECK PROBLEMS	□ BROKEN FACIAL BONES	□ HIATAL HERNIA/ULCERS
□ ASTHMA	□ SHORTNESS OF BREATH	□ LIVER DISEASE	□ HEPATITIS
□ PREGNANT	□ GLAUCOMA	□ CHRONIC COUGH	□ KIDNEY DISEASE
□ RESTLESS LEG SYNDROME	□ CLAUSTROPHOBIA	□ URINARY RETENTION	□ BLEEDING/CLOTTING ABNORMALITIES
□ SLEEP APNEA/USE CPAP	□ COPD/EMPHYSEMA		

(Continued on back)

PAIN ASSESSMENT SCALE: 1 2 3 4 5 6 7 8 9 10 (1 = NO PAIN 10 = SEVERE PAIN)

IF YOUR PAIN IS ABOVE A 3, PLEASE EXPLAIN WHY: _____

ARE YOU THE PAST OR PRESENT CARRIER OF A CONTAGIOUS DISEASE? _____

SMOKER: ____ YES ____ NO AMOUNT: _____ ALCOHOL: ____ YES ____ NO AMOUNT: _____

ARE YOU A CURRENT OR FORMER SMOKER (CIGARETTES): ____ YES ____ NO PACKS/DAY? _____

WHEN? _____

DO YOU DRINK ALCOHOL? _____ YES _____ NO AMOUNT PER WEEK? _____

DO YOU USE OR HAVE YOU USED RECREATIONAL DRUGS? _____ YES _____ NO

WHAT TYPE OF DIET DO YOU FOLLOW: _____ REGULAR _____ DIABETIC _____ OTHER _____

HAVE YOU TAKEN CORTISON OR STERIODS IN THE PAST YEAR? _____ YES _____ NO

DO YOU HAVE ANY OF THE FOLLOWING? ____ DENTURES ____ BRIDGEWORK ____ PARTIAL PLATES ____ CAPS
____ CONTACTS ____ HEARING AIDS

PAST SURGERIES: _____

_____

MEDICAL/SURGICAL PROBLEMS: _____

_____

PLEASE LIST ALL THE MEDICALS YOU TAKE ON A REGULAR BASIS. (INCLUDE OVER THE COUNTER MEDICATIONS, VITAMINS AND THOSE PRESCRIBED BY YOUR DOCTOR:

MEDICATION	DOSAGE	HOW OFTEN

_____

Patient Signature/ Date

_____

Nurses Signature/ Date

☐ Medications Reconciled

EPS Surgical Medical Clearance Form

Medical clearance is needed from your primary care physician **before your date of surgery.**

Your primary care physician should complete the attached form.

Please print a copy and take to your primary care physician's office for them to complete. **We ask that you assist us in ensuring your primary care physician completes this form in a timely manner.** If you are unable to take to their office, please direct them to our website at www.atlantaeye.com, and click on **Surgical Patient Forms**.

Upon completion of the form, please fax to:
Attention: VIP Services
Fax # (404) 294-3353
Alternate Fax # (404) 294-9361

If you have any questions, please contact us via phone at (404) 292-2500.

Eye Physicians and Surgeons, PC
1457 Scott Blvd - Decatur, GA 30030

Laura A. Bealer, MD
Indira Menon, MD
Ajeet Dhingra, MD
Shalin Shah, MD
Ronak Patel, MD

MEDICAL CLEARANCE REQUEST FOR EYE SURGERY

Dr. _____ Phone: _____ Fax: _____

Dr. _____ Phone: _____ Fax: _____

The patient listed below has requested and potentially scheduled for eye surgery pending medical clearance.

PATIENT NAME: _____ DATE OF BIRTH: _____
DIAGNOSIS: _____ PROCEDURE: _____
ANESTHESIA: TOPICAL WITH MAC

******The above patient requires the following items for medical clearance:**

- **YOUR CLINIC OFFICE NOTES that include the patient's history, physical, and list of medications. Please evaluate their general health.**
- **Lab Bloodwork and Results within 6 months to 1 year.**
- **EKG acceptable within 6 months to 1 year.**
- **If the patient is diabetic, we will need the last A1c: _____.**

IF THE PATIENT NEEDS TO BE SEEN BY YOU IN ORDER TO GIVE MEDICAL CLEARANCE, PLEASE HAVE YOUR STAFF CONTACT THE PATIENT ASAP TO SCHEDULE A VISIT.
Generally, we will not place patients who request procedures on our surgery schedule until we have received a clearance.

Please complete the following:
Patient's Current Weight: _____ Height: _____ BMI: _____

*****Please Check ONE Below:**

___ OPTIMIZED FOR SURGERY This patient's medical condition is STABLE to undergo surgery with topical and monitored anesthesia care in an ambulatory surgery center setting.

___ NOT OPTIMIZED FOR SURGERY This patient's medical condition is NOT STABLE for surgery with topical and monitored anesthesia care in an ambulatory surgery setting.

_____ _____ _____
PCP or Specialist Signature Date Phone Number

PLEASE FAX THIS COMPLETED FORM, YOUR OFFICE NOTES, LABS, AND EKG TO

404-294-3353

If you have any questions, please contact our Surgical Coordinators:

Lori Crawford	Dione Thomas	Kristin Hedgepeth	Mavis Norwood
404-267-6703	404-294-3174	678-904-7235	404-267-6781