

# OMNI EYE SPECIALISTS

A Madison Street Company® Proudly Owned by Employees

*Specializing in Medical and Surgical Care of the Eye*

55 Madison Street, Suite 355, Denver, CO 80206

6881 South Yosemite Street, Centennial, CO 80112

303-377-2020 800-GO-2-OMNI

[www.omnieye.com](http://www.omnieye.com)

See Dr. \_\_\_\_\_ after \_\_\_\_\_ but before \_\_\_\_\_ (deadline).

**NOTE:** Please take this form to your primary care physician and have a pre-operative history and physical, EKG, and any necessary labs performed between the dates listed above.

**\*THE PRE-OP HISTORY & PHYSICAL, EKG AND ANY NECESSARY LABS MUST BE COMPLETED WITHIN TWO WEEKS OF SURGERY\***

Patient Name: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Surgery Date(s): \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD(s): \_\_\_\_\_ CPT(s): \_\_\_\_\_

## **PRE-SURGICAL REQUIREMENTS:**

1. Complete History & Physical Form (on the next page)
2. EKG(with interpretation) - required for all males over 40, females over 50 and anyone with a cardiac history. The EKG MUST be approved and documented by your Primary Care Physician (PCP). You must be cleared for surgery with written documentation (an abnormal EKG will NOT be accepted without written clearance from your PCP). Your surgery will have to be CANCELED if we do not receive written clearance from your PCP.
3. Blood Work - as deemed relevant and necessary by your PCP. If it is decided that no blood work is necessary, your PCP MUST indicate “no labs needed, patient cleared for surgery,” on the pre-op form. Lab results MUST be approved and documented by your PCP.

## **SPECIAL INSTRUCTIONS: Fax to (303) 377-3234 Attn: Surgery Scheduling\***

1. Pre-operative physicals and testing must be performed within 30 days of your surgery and are **valid for 30 days** per insurance standards. IV Sedation will be used.  
**PRE-OP EXAMS CANNOT BE COMPLETED BY OUR OFFICE.**
2. Please fax completed results to the Surgical Schedulers at Omni Eye Specialists  
**THREE BUSINESS DAYS PRIOR TO SURGERY.**

Patient signature for release of information: X \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Vital Signs:**

B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration: \_\_\_\_\_ Temp \_\_\_\_\_

**History:**

**Chief Complaints:**

**Present Illness:**

**Family History:**

**Medical History:**

**Previous Surgery(s) / Anesthesia:**

**Allergies /Drug Sensitivities:**

**Bleeding Tendencies:**

**Medications:**

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**Physical Examination:**

**General Appearance - nutrition - pallor:**

**HEENT:**

**Lymphatic:**

**Neck:**

**Extremities:**

**Chest & Lungs:**

**Musculo-Skeletal:**

**Cardiovascular:**

**Neurological:**

**Abdomen:**

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**Diagnostic Impression:**

**Plan:**

**Patient Cleared for Surgery** please circle one                      **YES**              **NO**

**Labs Needed:** please circle one                                      **YES**              **NO**

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**Physician's Name (Printed)**

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**Physician's Signature**

**Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_