Landmark Surgery Center Cardiac Clearance Form

(please return ASAP to support@executiveplasticsurgery.com or fax: 248.934.2185)

Patient Name: _____ Today's Date: ____/_____/_____ Pt. DOB:_____/_____/_____

Surgeon: **Dr. Shaher W. Khan MD** Date of Surgery: _____/_____/_____

Procedure: Removal of breast implant(s) and capsules, total capsulectomy Diagnosis: Breast Implant Illness

Anticoagulation Therapy Plan: **Stop prior to surgery:**

Can the patient stop the anticoagulant prior to surgery? ☐ No ☐ Yes; Number of Days: _____

Can the patient stop aspirin prior to surgery? ☐ No ☐ Yes; Number of Days: _____

Does the patient require: ☐ Bridging Heparin ☐ Low Molecular Heparin

If so, plan: _____

When should the patient start their anticoagulant after surgery? _____
(Patients undergoing spinal anesthesia need to be off blood thinner for 7 days)

Does the patient have a…? ☐ Pacemaker ☐ Pacemaker / ICD
Is the patient pacer dependent? ☐ Yes ☐ No

Test	Test Available - Attached	Test Not Available
Echocardiogram		
Stress Echo		
Exercise Stress Test		
ECG **(patients over 50 years and ECG within 6 months)**		
Cardiac Catheterization		

Clearance Risk: ☐ **Low Risk** ☐ **Moderate Risk** ☐ **High Risk**

_____

_____

Cardiologist Signature: _____ Date: ___/___/____ Time: _____ Phone: (_____) _____

*****THE PATIENT CANNOT HAVE SURGERY UNTIL ALL QUESTIONS BELOW ARE COMPLETED*****

Is the patient cleared to have surgery in an OUTPATIENT SURGICAL CENTER (no 24 hr observation)? _____ YES _____ NO
If no- please explain:_____

Is the patient cleared to have surgery in an OUTPATIENT HOSPITAL SETTING? _____ YES _____ NO
If no- please explain:_____

Is the patient cleared to have General Anesthesia if needed? _____ YES _____ NO
If no- please explain:_____

Cardiac clearance is required from your cardiologist or physician treating your heart condition.This clearance is due **four** weeks before your surgery date. Please take this form to your physician's office for them to complete. We ask that you assist us in ensuring your physician completes this form. **If we do not receive your completed medical clearance form (NO LATER THAN) 2 weeks from the date of surgery at the latest, your surgery date will be rescheduled.**

Dr. Shaher W. Khan Reviewed: ____/____/_____ Time: _____am pm Signature: _____
MDA/CRNA Reviewed: ____/____/_____ Time: _____am pm Signature: _____

☐ On this day,Medical Clearance is reviewed with a physical exam- NO changes within 30 days of the surgical date.
☐ On this day, Medical Clearance is reviewed with a physical exam- YES changes within 30 days of the surgical date:
_____

43940 Woodward Ave. Suite 200 Bloomfield Hills, MI 48302 Office: (734) 419-1615 / Fax: (248) 934-218