McLaren
CARDIOVASCULAR GROUP

2134 Hampton Place
Okemos, MI 48864
Phone: 517-347-3000 Fax: 347-8393

Cardiac Clearance Request Form

Our mutual patient, _____

DOB_____

Is scheduled for an emergent or elective procedure. (please circle)

Procedure name is: _____
_____
on Date:_____ Time: _____ with Dr_____

They will be receiving _____ for sedation.

Office Contact Person _____ Fax Number _____

We are requesting:

_____ 1. Cardiac Clearance only without medication being addressed

_____ 2. Cardiac Clearance with Anticoagulation Recommendations…
Name of Medication: _____
___ discontinue 7 days prior to procedure
___ discontinue 5 days prior to procedure
___ discontinue 7 days prior to the procedure & bridge with low weight heparin i.e. Lovenox, Fragmin
___ other _____
_____

3. Would your patient require prophylactic antibiotics? **Yes** or **No** (please circle)

Please fax this sheet to 517-347-8393 ATTN: Clinical Nurse

Please Note:
***Routine requests will be processed within 2 weeks from date of request.**
*** Urgent or Emergent requests will be processed immediately.**