

Referral to:	
Referring MD:	
Patient Name:	DOB:
Planned Procedure:	
Desired/Planned Date of Procedure:	
Reason for Consult: Requested interruption in anti-platelet therapy	

A. APPROPRIATENESS OF PLANNED PROCEDURE:

Antiplatelet Medicine Reason for use:	
<input type="checkbox"/> Coronary Disease	Placed: <input type="checkbox"/> MORE than 1 year ago <input type="checkbox"/> LESS than 1 year ago
<input type="checkbox"/> Drug Eluting Stent	<i>NOTE: Document below the reason it is okay to proceed with elective case if you have checked LESS than 1 year ago</i>
	Date Placed:
<input type="checkbox"/> Bare Metal Stent	Placed: <input type="checkbox"/> MORE than 6 wks ago <input type="checkbox"/> LESS than 6 wks ago
	<i>NOTE: Document below the reason it is okay to proceed with elective case if you have checked LESS than 6 weeks ago</i>
	Date Placed:
<input type="checkbox"/> Yes, it is appropriate and reasonable to proceed with procedure from a cardiac standpoint; supporting reason for "YES" if stent placement duration LESS than recommended time for a procedure:	
<input type="checkbox"/> No, it is not appropriate or reasonable to proceed with procedure. Must include reason:	

B. MANAGEMENT OF ANTI-PLATELET THERAPY:

Clopidigrel (Plavix)	Aspirin	Other Anti-platelet medications
<input type="checkbox"/> May NOT be stopped before the procedure	<input type="checkbox"/> May NOT be stopped before the procedure	<input type="checkbox"/> _____ may NOT be stopped before the procedure
<input type="checkbox"/> May be stopped _____ days before procedure	<input type="checkbox"/> May be stopped _____ days before the procedure; if patient has drug-eluting stent indicate reason (<i>NOT recommended to stop ASA in these cases</i>):	<input type="checkbox"/> Restart _____ ASAP after procedure
<input type="checkbox"/> Restart ASAP after procedure		<input type="checkbox"/> _____ may be stopped _____ days before procedure
<input type="checkbox"/> Restart within _____ days following procedure	<input type="checkbox"/> Restart ASAP after procedure	<input type="checkbox"/> Restart _____ within _____ days following procedure
	<input type="checkbox"/> Restart within _____ days following procedure	

C. OTHER COMMENTS: _____

Signature: _____, MD Printed Name: _____, MD

Date: _____

Please fax copy to referring MD and if procedure is already scheduled at SMH, please fax copy to:

Surgery 917-2202 Radiology 917-1554 Endo/Bronch 917-2870

**SARASOTA MEMORIAL HEALTH CARE SYSTEM
PRE-PROCEDURE CARDIOLOGY EVALUATION
FOR MANAGEMENT OF ANTI-PLATELET MEDICATIONS**



DON'T FORGET TO LABEL ALL COPIES. IF NO LABEL, MUST INDICATE PATIENT NAME, DATE OF BIRTH AND DOCTOR
PATIENT NAME
DATE OF BIRTH
DOCTOR:
PLACE PATIENT ID LABEL HERE