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| 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:

| Plavix (Clopidogrel) or Effient (Prasugrel) | 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: _____ Time: _____

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**



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| 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 | |