



Date: _____

Dear Dr. _____

Regarding our mutual patient: _____ DOB: _____

This patient **is** or **will be** scheduled for an endoscopic procedure on _____

This procedure will require: General Anesthesia Moderate sedation

Length of procedure: _____ Hours _____ Minutes

We are requesting cardiac clearance for (*Circle one*): *PROCEDURE* *ANTICOAGULATION* *BOTH*

1. PROCEDURES: Colonoscopy or Endoscopy (Please check the following)

- The patient is at low risk for surgery from a cardiac standpoint
- The patient is at **increased risk, but not prohibitive** from a cardiac standpoint. To **minimize risk**, we recommend the following:
 1. _____
 2. _____
 3. _____
- The patient is at **prohibitive risk** from a cardiac standpoint for the above procedure.

2. ANTICOAGULATION: Name of drug: _____

- The patient **May** **May Not** stop Plavix (clopidogrel) 5 days before the procedure
- The patient **May** **May Not** stop Coumadin (warfarin) 5 days before the procedure
- The patient **May** **May Not** stop _____x_____ 2 days before the procedure

COMMENTS:

Cardiologist Signature: _____ Date: _____