Cosmetic Surgery Clinics
31542 Pacific Coast Hwy.
S. Laguna Beach, CA 92651
Telephone: (949) 499-3915
Fax: (949) 499-2585

TAKE THIS FORM TO YOUR M.D. OR LAB

Patient: ____________________MR#________
Surgery Date: ___________________________

PLEASE ARRANGE THE F OLLOWING CHECKED ITEMS:

________ Letter of medical clearance from your medical doctor.

________ Complete physical examination by your medical doctor

________ Letter of medical clearance from your ophthalmologist

________ Visual eye field exam from ophthalmologist.

PRESURGICAL TESTING: **Four weeks before surgery** DX CODE ____________________

________ Please call Cosmetic Surgery Clinics to schedule testing at 949-499-3915.

________ Blood test at South Coast Medical Center 31872 Coast Highway, Laguna Beach (949.499.1311). The lab is located on the 1st floor from 7:30 am to 6 pm Monday through Friday. Please take this requisition with you. No appointment is necessary.

_______ EKG – Check in at the front desk at South Coast Medical Center. This can be done the same day as your blood testing. The requisition has been marked appropriately.

_______ Chest X-ray – This may be done by your medical doctor or if you have had a chest X-ray within six months of your surgery, please have a copy of the report, not the actual X-ray films, sent to our office.

_______ Mammogram

If your medical doctor wishes to complete your pre-surgical testing as part of your medical clearance or you are from out of town and wish to have your testing done locally, the following testing will be required. All lab results must be returned to our office 3 weeks before surgery. IT IS VERY IMPORTANT THAT YOU NOTIFY OUR STAFF IF YOUR TESTING IS DONE OUTSIDE OF OUR LAB.

____ CBC	____ Platelets	____ K	____ GLU	____ SGOT	____ BUN
____ PT	____ PTT	____ Bleeding time	____ NA	____ CO2	____ CL
____ CMP	____ BMP	____ Thyroid Function		____ Antigen	
____ ANA	____ Sed Rate	____ HIV	____Hep Panel		
____ Von Willebrand's Factor 8		____ Coagulation Activity		____ Restocetin Cofactor	
_____Rheumatoid Factor					

____ (Signature)

Date: _______ Patient: ________________________________ Instructed by: ____________________