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CARDIOVASCULAR RISK ASSESSMENT AND ANTICOAGULATION/ANTIPLATELET THERAPY MANAGEMENT FORM

PATIENT NAME/ Date of Birth: _____

PROCEDURE NAME: **CIRCLE ONE:** Upper Endoscopy/Colonoscopy/EUS/ERCP with possible biopsy, dilation of tissue

DATE OF PROCEDURE: _____

PHYSICIAN ASSESSMENT BELOW (May use your own Clearance form if needed).

CIRCLE ONE: PATIENT IS **LOW /MODERATE** / **HIGH** RISK FOR THE PROCEDURE.

OK TO HOLD ANTICOAGULATION/ANTIPLATELETS FOR ____ DAYS

COMMENTS OR CONCERNS IF HIGH RISK/ DENIAL OR CONTRAINDICATIONS_____

_____

NAME/SIGNATURE OF PHYSICIAN PERFORMING THE ASSESSMENT

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*NOTE TO THE PRIMARY CARE PROVIDER/ CARDIOVASCULAR PHYSICIAN/ CONCERNED CARE TEAM STAFF

Please call the patient if bridging therapy is needed when blood thinners are stopped. Please inform the patient when to hold the blood thinners and when to restart blood thinners.

PLEASE FAX COMPLETED CLEARANCE/ASSESSMENT to FAX # 812 814 9707

URGENT MATTERS- CALL OUR **GI VIP ACCESS LINE Ph # 812 878 4881** or **Office phone line 812 814 3417**