

patient identification

Coronary Stent/Mechanical Heart Valve/Atrial Fibrillation with History of Stroke Plan of Care Form

(Form may be used for any other patient as well)

SURGEON SECTION - MUST BE COMPLETED PRIOR TO CARDIOLOGY/PRESCRIBING PHYSICIAN EVALUATION

Procedure Date (if known): N/A Procedure: BARIATRIC SURGERY
GENERAL

Surgeon: _____ Anesthesia Type: _____
(Instructions: fully complete either statement #1 OR Statement #2 and then sign)

1) Patient is asymptomatic from a cardiac standpoint and may continue all antiplatelet and anticoagulants agents as prescribed throughout the perioperative period (no cardiology evaluation required, surgeon instructs patient to continue medications)

2) Cardiology Evaluation for:
 Medical/cardiac optimization
 Risk stratification/cardiac clearance
 Recommendations for perioperative anticoagulants and anti-platelets (see acceptable list below)

Acceptable to continue Peri-op: Aspirin 81 mg Aspirin 325 mg Clopidogrel (Plavix)
 All None Other:

***** By signing below, the surgeon acknowledges responsibility for instructing their patient on Antiplatelet/anticoagulation management (after cardiology/prescribing physician evaluation if required).**

Surgeon signature _____ Date/time _____
 Contact phone number 919-784-2836 Fax number 919-784-2850

CARDIOLOGIST/PRESCRIBING PHYSICIAN SECTION
(Instructions: review surgeon section above and complete applicable sections below before signing)

This patient is medically optimized.
 This patient is at low / medium / high risk for cardiac events in the perioperative period.
 Anticoagulant/antiplatelet recommendations*:

Antiplatelet	Continue	Last dose ____ days Pre-op	Anticoagulant	Continue	Last dose ____ days Pre-op
Aspirin			FONDAPARINUX (Arixtra)		
TICAGRELOR (Brilinta)			WARFARIN (Coumadin)		
PRASUGREL (Effient)			APIXABAN (Eliquis)		
CLOPIDOGREL (Plavix)			DABIGATRAN (Pradaxa)		
CILOSTAZOL (Pletal)			EDOXABAN (Savaysa)		
TICLOPIDINE (Ticlid)			RIVAROXABAN (Xarelto)		
Other:			Other:		

***Antiplatelets and anticoagulants should be resumed as soon as clinically possible after surgery**

Bridging instructions, if needed:

Other recommendations/comments:

By signing below, the cardiologist or other prescribing physician acknowledges communication of his/her recommendations to the surgeon prior to the scheduled surgery.

Cardiologist (print): _____ Contact phone number: _____
 Signature: _____ Date: _____

