# Anticoagulant Clearance Form

## SpineCare Delaware

**Phone: 302-894-1900**

**Fax: 302-894-0264**

Date: _____

Doctor_____,

our mutual patient _____Dob_____, is scheduled

for a _____ spinal procedure that involves IV conscious

sedation with Versed and or Fentanyl and the use of corticosteroids and or local anesthetics.

Please check the following that applies for your patient:

____ The patient is **Cleared** to stop _____3 days prior to the procedure.

____ The patient is **Not Cleared** to stop _____3 days prior to the procedure.

Comments:

_____

_____

Clearance will be valid for 90 days due to possible multiple procedures

Signature of Physician_____

Should you have any questions, please contact our Ambulatory Surgery Center at 302-894-1900.

**Please fax the completed clearance form to 302-894-0264**

Sincerely,

Bonnie O'Connor, PAC