



**Patient Name:** \_\_\_\_\_

**Date Of Surgery:** \_\_\_\_\_

**Do you take any of the following:**

**Apsirin**    \_\_\_ Yes    \_\_\_ No

**Plavix**    \_\_\_ Yes    \_\_\_ No

**Coumadin**    \_\_\_ Yes    \_\_\_ No

**Other Blood Thinners**    \_\_\_ Yes    \_\_\_ No

**I understand that I must be off all blood thinners 7 days prior to my date of surgery.**

**I understand that my surgery will be cancelled if I am taking any of these products.**

\_\_\_\_\_  
**Patient**

\_\_\_\_\_  
**Physician**