

Four Peaks Surgery Center  
9425 W Bell Rd   
Sun City AZ, 85351  
*ph*: 623-399-6880  
*fax*: 623-322-1504

TO: Dr. **drName**

Phone: pNumber

Fax: fNumber

Date: dateOfFax

We would like to schedule this patient **[procedureName]** Our records indicate this patient is taking one or more anticoagulant medications. **Please sign below and fax back to** **us if patient can stop their anticoagulant prior to the procedure.**

**DOB: dateOfBirth**

**PT: ptName**

**SURGERY DATE: procedureDate**

Stop Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resume Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accepted by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MD Signature Printed Name Date