HERON ROCK
SURGERY CENTER OF LANCASTER

484-588-2583

606 COMMUNITY WAY,
LANCASTER, PA 17603

WWW.HERONROCKSURGERY.COM

REQUEST TO HOLD BLOOD THINNER

Patient's Name:_____DOB:_____
Type of Surgery:_____
Date of Surgery: _____
Surgeon: Kenneth Morgenstern, MD
Location: Heron Rock Surgery Center of Lancaster

Dear Dr_____,

Our records indicate that this patient is on blood thinner(s). Please provide your instructions below:

- ❑ **HOLD**:

1. Medication:_____

   STOP_____days before surgery; RESUME_____days after surgery.

2. Medication:_____

   STOP_____days before surgery; RESUME_____days after surgery.

3. Medication:_____

   STOP_____days before surgery; RESUME_____days after surgery.

- ❑ **LOVENOX BRIDGING REQUIRED**:

  Instructions: _____

Name of Prescribing Physician:_____

Signature_____Date_____

Please FAX the completed form to (610)687-8773 at your earliest convenience. Thank you!