Pre-Surgical Medical Clearance Request

Dear Doctor,

Our Mutual patient was diagnosed with an extensive dental treatment plan under *General Anesthesia*; which may include radiographs, prophylaxis, fillings, including any other major dental restorations.
We require your medical clearance and any precautions or contraindications which will interfere.
General Anesthesia will be administered by Dental Anesthesia, LLC

Patient Name: _____

Date Of Birth: _____ Current Weight: _____

Treating Dentist: _____

Requesting Office:

☐ *Glendale Location*
4901 W Bell Rd Suite 100,
Glendale, AZ 85308
Office: (602) 843-1275
Fax: (602) 843-1276
fronttcfkbell@gmail.com

☐ *Phoenix Location*
7777 N 43rd Avenue
Phoenix, AZ 85051
Office: (602) 888-7844
Fax: (602) 661-7720
frontofficetcfkphx@gmail.com

☐ *PCH Location*
1701 E Thomas Rd Suite 204
Phoenix, AZ 85016
Office: (602) 253-6600
Fax: (602) 279-0821
anoemitcfkpch@gmail.com

All results should be Faxed, or presented to our office at least 7 business days prior to surgery date.

Doctor Please Complete Section Below

Is this patient cleared for dental treatment under General Anesthesia? ☐ No ☐ Yes

Would you recommend any treatment modifications? ☐ No ☐ Yes

If Yes, specify: _____

Comments: _____

_____

Doctor: _____ Date: _____

Office Address: _____ Office: ( ) -

Please Fax to the Requested Location most recent H&P, Relevant labs/diagnostics

ARIZONA DENTAL ANESTHESIA

❖ History & Physical Evaluation ❖

Prior to Dental Treatment Utilizing Office-Based General Anesthesia

TO BE COMPLETED BY PATIENT'S PRIMARY CARE PHYSICIAN

Patient's Name: _____ DOB: _____

History of Present Illness:	CNS: ☐ Normal ☐ Abnormal
Past Medical History:	Psychiatric or Behavioral: ☐ Normal ☐ Abnormal
Current Medications: ☐ None	Gastrointestinal: ☐ Normal ☐ Abnormal
Family & Social History:	Endocrine: ☐ Normal ☐ Abnormal
Allergies: ☐ Latex ☐ Foods/Dyes ☐ Seasonal/Animals ☐ Drug	Musculoskeletal: ☐ Normal ☐ Abnormal
Cardiovascular: ☐ Normal ☐ Abnormal ☐ Requires SBE Prophylaxis Prior to Invasive Dental Care	Hematologic: ☐ Normal ☐ Abnormal
Pulmonary: ☐ Normal ☐ Abnormal ☐ Recent h/o URI or Illness ☐ h/o COVID-19 Infection	HEENT: ☐ Normal ☐ Abnormal
Genitourinary: ☐ Normal ☐ Abnormal	Skin or Hair: ☐ Normal ☐ Abnormal

Personal Stats: Weight. ____ kg/lbs Height. ____ cm/inches BMI. ____	Vital Signs: BP. ____/____ HR. _____ bpm SpO_2. _____% RR. _____ bpm Temp. _____ °C/F

Diagnosis/Overall Impression:

☐ No Increase in Risk w/ GA ☐ Minimal Increase in Risk w/ GA

☐ Moderate Increase in Risk w/ GA ☐ Severe Increase in Risk w/ GA

Due to the extent of needed oral rehabilitation, coupled by the patient's inability to cope with invasive dental care and/or a current medical condition, the patient's dentist has recommended that dental treatment be completed using office-based deep sedation/general anesthesia on an outpatient basis. Prior to the initiation of such care, both the dentist and anesthesiologist will review all potential risks, benefits, and alternatives to deep sedation/general anesthesia with the patient or legal guardian so that an informed decision can be made.

As this individual's primary care physician, I am providing the above medical information to assist the anesthesia and surgical teams in their consideration for the use of deep sedation/general anesthesia to complete needed dental care. I understand that this document is not intended to provide medical consent, nor does it release the anesthesia and surgical teams from liability in the event of a complication. _____

_____

_____ _____

Signature of Physician or Authorized Medical Representative *Date*

Please Fax to the Requested Location most recent H&P, Relevant labs/diagnostics