Consultation Request Form

The Patient below is scheduled for oral and or extensive dental restoration surgery and will need:

☐ **General Anesthesia with intubation**

☐ **MAC - IV Sedation**

Anticipated Duration of Surgery _____ Hours

Please evaluate and provide the requested information

Patient Name _____

DOB: _____

Requesting Information:

☐ **Medical Clearance Consult Letter** (Also Include any additional tests below)

☐ _____

_____

☐ EKG- Acceptable within last ☐ 6 months ☐12 Months

☐ Results from last Echocardiogram

☐ Results from last stress test

☐ CBC ☐ Chem 7 ☐ PT/PTT/INR ☐ _____

☐ **Cardiac Clearance Consult Letter** (Also Include any additional tests below)

☐ _____

_____

☐ EKG- Acceptable within last 6 months

☐ Results from last Echocardiogram

☐ Results from last stress test

☐ **Other Clearance** _____

☐ Other information _____

_____

_____

☐ **Medical Records** _____

Please forward material to:

Requesting Doctor's Office: Safe Dental Sedation (Advanced Dental Anesthesia PLLC)

Contact Phone: 703-662-3166

HIPAA FAX: 502-385-6689

HIPAA EMAIL: Info@SafeDentalSedation.com