Safe Dental Sedation

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)

☐ ______________________________

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☐ 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)

☐ ______________________________

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☐ EKG- Acceptable within last 6 months

☐ Results from last Echocardiogram

☐ Results from last stress test

☐ **Other Clearance** ______________________________

☐ Other information ______________________________

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☐ **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