Dr David Westerhaus
Pre-Anesthesia Medical Evaluation

Dear Physician:

I am requesting your medical evaluation of the patient referenced below. Because of this patient's inability to cooperate in a dental setting and/or the extent of dental care required, his or her dentist has recommended that dental treatment be completed under intravenous sedation/ general anesthesia. Thank you for completing this evaluation and assisting me in providing excellent health care for our patient. If you wish to discuss this case with me, please feel free to call me at 916-827-0046.

Please also forward a copy of any relevant labs, reports from specialists, operative reports, and any pertinent medical records.

Patient Name: _____ **DOB:** _____ Age: _____ Sex: _____

Significant Medical History: _____

Hospitalizations: _____

(*Please include dates & reasons*)

Anesthetic History: (complications) ***Patient*****:** _____ ***Family*****:** _____

Medications: _____ **Allergies:** _____

Physical Exam: Height: _____ Weight: _____ Blood Pressure: ____/_____Temp:____ Pulse: _____ Resp:_____ SpO2:____

(Please include units of height and weight)

	WNL	Abnormal (Explain)
General Health		
Cardiac		
Murmur		
Defect		
Respiratory		
Asthma		
Sleep Apnea		
Liver		
Genitourinary		
Neurological		
Seizures		

	WNL	Abnormal (Explain)
Genetics		
Endocrine		
Metabolic		
Hematology		Hgb:
G.I.		
GERD		
HEENT		
Skin		
Muscular-		
Skeletal		
Other:		
Airway:		
Tonsils:		1+ 2+ 3+ 4+

Based on this patient's health history, is this patient a good candidate for outpatient dental treatment under intravenous sedation/ general anesthesia in an outpatient dental setting?

Yes_____ No_____ (*please comment below*)

_____

_____

_____

Evaluating Physician Name: _____ Telephone: (_____) _____ - _____

(*Please print legibly the name of the evaluating physician whose signature appears below)*

Signature: _____ Date: _____

Please fax this completed form to the following dental office:

Office Name _____ Tel _____ Fax _____