

## 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)
<b>General Health</b>		
<b>Cardiac</b>		
Murmur		
Defect		
<b>Respiratory</b>		
Asthma		
Sleep Apnea		
<b>Liver</b>		
<b>Genitourinary</b>		
<b>Neurological</b>		
Seizures		

	WNL	Abnormal (Explain)
<b>Genetics</b>		
<b>Endocrine</b>		
<b>Metabolic</b>		
<b>Hematology</b>		Hgb:
<b>G.I.</b>		
GERD		
<b>HEENT</b>		
<b>Skin</b>		
<b>Muscular-</b>		
<b>Skeletal</b>		
<b>Other:</b>		
<b>Airway:</b>		
<b>Tonsils:</b>		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 \_\_\_\_\_

The protected health information (PHI) contained in this fax is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific dental / health care services to this patient. Any other use if a violation of federal law (HIPPA) and will be reported as such. If you have received this fax in error, please immediately notify us by phone to arrange for the return of the documents.