HANANESTHESIOLOGY

Neurology Seizure Clearance Request

Dear Physician,

Please provide your expert opinion regarding the patient's neurologic condition to receive anesthesia for dental surgery.

Return to: office@hananesthesiology.com or fax at 214-614-7484. Thank you.

PATIENT INFORMATION

Name: _____ Date of Birth: _____

DIAGNOSIS

Patient's Diagnosis: _____

HISTORY

What type of seizures does the patient experience: _____

Frequency of Episodes: _____

Provoking Factors: _____

Alleviated by: _____

History of Status Epilepticus: _____

MEDICATIONS

Current Seizure Medications: _____

_____

Do you recommend obtaining levels for any of the following medications prior to anesthesia? Please explain why or why not.

☐ Yes ☐ No

_____

_____

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PHYSICIAN OPINION AND ATTESTATION

1. Does the patient require a further neurological evaluation at this point? _____
2. Possibility of a **status epilepticus** compared to general public

   ☐ negligible ☐ slight ☐ moderate ☐ significant

3. How safe is it for the anesthesiologist to administer medications which decrease seizure threshold (e.i. Ketamine, Sevoflurane, etc.)

   ☐ Very Safe ☐ Slight Risk ☐ Moderate Risk ☐ High Risk (do not administer)

4. Physician Specialty: ☐ Primary ☐ Neurology

Comments: _____

I _____ (physician name/title) attest to the accuracy of the information and the opinion provided herein.

Signature: _____ Date: _____