HANANESTHESIOLOGY

Pediatric Medical Clearance Request

Dear Physician,

Please provide your expert opinion regarding the patient's medical fitness to undergo general anesthesia for dental surgery.

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

PATIENT INFORMATION

Name: _____ Date of Birth: _____

RECENT VITAL SIGNS & PHYSICAL EXAM: Date Taken: _____

Height: _____ (in/cm) Weight: _____ (lbs/kg) Resp Rate: _____

Blood Pressure: _____ SpO2: _____ HR: _____ Temp: _____

MEDICATIONS AND ALLERGIES

Medications: No ☐ Yes ☐ _____ Allergies: No ☐ Yes ☐ _____

HISTORY: Check if no, Check and explain if yes.

Asthma: No ☐ Yes ☐ _____ Pulmonary Disease: No ☐ Yes ☐ _____

Diabetes: No ☐ Yes ☐ _____ Heart Disease/Defect: No ☐ Yes ☐ _____

Seizures: No ☐ Yes ☐ _____ Exposure to Varicella: No ☐ Yes ☐ _____

Heart Murmur: No ☐ Yes ☐ _____ Sickle Cell/Variant: No ☐ Yes ☐ _____

Family Disease of Bleeding, Muscle Disease, or Anesthesia Complications: No ☐ Yes ☐ _____

Previous Surgery: No ☐ Yes ☐ _____ Other Conditions: No ☐ Yes ☐ _____

Previous Surgical Complication: No ☐ Yes ☐ _____

PHYSICIAN OPINION AND ATTESTATION

Is the patient optimized from a medical standpoint? ☐ Optimized ☐ Not Optimized

Does the patient require further medical evaluation? _____

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

Signature: _____ Date: _____