HANANESTHESIOLOGY

Cardiovascular Clearance Request

Dear Physician,

Please provide your expert opinion regarding the patient's cardiovascular fitness to undergo 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

Date: _____ Blood Pressure/HR: _____ SpO2: _____

CARDIOVASCULAR CONDITIONS AND TREATMENT

Presenting Conditions: _____

Current Medications: _____

DIAGNOSTICS

Has the patient had any of the following diagnostics?

• ECG	☐ No	☐ Yes (please attach report)
• ECHO	☐ No	☐ Yes (please attach report)
• Stress Test	☐ No	☐ Yes (please attach report)
• Any other tests (_____)	☐ No	☐ Yes (please attach report)

HIGH RISK CONDITIONS/PRESENTATIONS (FOR OFFICE-BASED ANESTHESIA)

Does the patient have any of the following cardiovascular conditions?

☐ Pulmonary Hypertension ☐ EF <= 40% ☐ Untreated CAD ☐ MI within 12 months

☐ Heart Block ☐ Prolonged QT ☐ A-Fib w/ RVR ☐ Other High Risk: _____

AICD/PACEMAKER

☐ None ☐ AICD, Pacemaker, or Both (Please attach the most recent interrogation report)

Underlying Rhythm: _____ Pacemaker Dependent: _____

Pacemaker Mode: _____ Magnetic Action: _____

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REVASCULARIZATION PROCEDURES (MOST RECENT ON TOP)

Date	Procedure (balloon, stent, CABG, etc.)	Type (DES, BMS, etc.)	Outcome

ANTICOAGULANT RECOMMENDATIONS

Medication	May Hold?	For how many days?	Comments

PHYSICIAN OPINION AND ATTESTATION

1. Does the patient require a further cardiology evaluation at this point? _____
2. Possibility of MACE compared to general public: ☐ negligible ☐ slight ☐ moderate ☐ significant
3. Physician Specialty: ☐ Primary ☐ Cardiology

Comments: _____

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

Signature: _____ Date: _____