HANANESTHESIOLOGY

Cardiovascular Clearance Request for General Anesthesia

Dear Physician,

We kindly request you complete the following information and return it to us, so that we can determine if the patient can undergo **general anesthesia** safely for oral surgery in a dental clinic.

PATIENT INFORMATION

Name: _____ Date of Birth: _____

DOCUMENTS REQUESTED

1. Recent and any other relevant **visit summary notes**
2. Recent and any other relevant **diagnostics**, such as ECG, ECHO, Stress Test, etc.

Are there any recent changes that are not reflected in your attached documents? _____

_____

HIGH RISK CONDITIONS

Please indicate if the patient has:

☐ Pulmonary Hypertension ☐ Elevated RVSP ☐ CHF ☐ A-Fib on RVR

☐ Pacemaker or AICD ☐ Heart blocks ☐ Prolonged QT ☐ Hx of revascularization

PHYSICIAN OPINION AND ATTESTATION

Note: Final determination of Anesthesia Clearance will be made by the anesthesiologist, based on the information provided herein.

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

Possibility of MACE compared to the General Public: ☐ Negligible ☐ Slight ☐ Moderate ☐ Severe

May the patient hold anticoagulants for surgery? ☐ Yes ☐ No ☐ N/A

Comments: _____

_____

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

Signature: _____ Date: _____

Han Anesthesiology PLLC d/b/a The Dream Pros Dental Anesthesia | 3408 Verona Dr. Corinth, TX 76210