HANANESTHESIOLOGY

Neurology 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? _____

_____

MEDICATIONS

Current Seizure Medications: _____

_____

Do you recommend obtaining levels for any medications prior to anesthesia? ☐ Yes ☐ No

PHYSICIAN OPINION AND ATTESTATION

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

Possibility of a **status epilepticus** ☐ Negligible ☐ Slight ☐ Moderate ☐ Significant

Comments: _____

_____

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

Signature: _____ Date: _____

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