MEDICAL CLEARANCE

For Dental Treatment Under General Anesthesia

Redlands Dental Surgery Center, 1180 Nevada Street # 100, Redlands, CA 92374, (909) 335-0474

Patient Name: _____ DOB: _____

Form received by: _____ Date: _____
Patient / Parent / Guardian / Other: _____

I authorize the release of any information necessary to process this request:

_____ _____
Patient / Parent / Guardian / Other: _____ Date

- To be completed by Physician -

Medications:

- ☐ No known medications being taken
- ☐ List medications being taken _____

_____

Patient's Medical Conditions:

- ☐ No known medical condition
- ☐ List medical condition(s)

_____

_____

1. Are there contraindications for dental treatment under IV general anesthesia at an outpatient surgery center?
   YES ☐ NO ☐
   If yes, what are they? _____
2. Are there recommendations for dental treatment under IV general anesthesia at an outpatient surgery center?
   YES ☐ NO ☐
   If yes, what are they? _____
3. Does patient require antibiotic prophylaxis? YES ☐ NO ☐
   If yes, what is the indication? _____

MUST ATTACH:

- Current **History & Physical** (not 'Physician's Report for Community Care Facilities')
- Current progress note
- Current lab work
- Current test results: EKG, ECHO, sleep study, other; if needed
- Other (requested by RDSC anesthesiologists) _____

Send completed form and requested documents to:
(909) 912-8800 (fax) or redlandsdental1@gmail.com

_____ _____ _____
Physician Signature Date Office phone number

_____ _____ _____
Physician Name (print) Office address Office fax number

This form is valid for 30 days once signed by a physician