Jeffrey P. Fisher, DDS

"Anesthesia for Little People"

Pre-anesthesia Medical Evaluation

Dear Physician:

I am requesting your medical evaluation of the patient referenced below. Because of this patient's inability to cooperate in a dental setting and/or the extent of dental care required, his/her dentist has recommended that dental treatment be completed under *IV* deep sedation / general anesthesia, utilizing my services as a hospital-trained dental anesthesiologist. If you wish to discuss this case with me, please feel free to call my cell phone at 916-390-3673. Thank you for completing this evaluation and assisting me in providing excellent health care for my patient.

Sincerely, Jeffrey P. Fisher

Patient Information:

Patient Name: _____ DOB: _____ Age: _____ Sex: _____

Significant Medical History: _____

Hospitalizations: _____

(*Please include dates & reasons.*)

Surgical History: ***Patient***: _____ ***Family***: _____

Medications: _____ **Allergies:** _____

Physical Exam: Height:_____ Weight:_____ Blood Pressure:_____/_____ Temp:_____ Pulse:_____ Resp:_____

	WNL	Abnormal (explain)
General Health		
Skin		
HEENT		
Neck		
Cardiovascular		
Respiratory		
Endocrine		

	WNL	Abnormal (explain)
Metabolic		
Gastrointestinal		
Liver		
Muscular/Skeletal		
Central Nervous Sys.		
Genitourinary		
Hematology		

Airway Assessment: _____

Medical Alert: Are there any medical conditions based on this patient's history that would prevent them from safely receiving *IV* deep sedation or general anesthesia in an out-patient dental operatory setting?
☐ No ☐ Yes (*If so, please explain below*)

Remarks: _____

_____

Evaluating Physician:

Name: _____ Telephone: (_____) _____ - _____

(*Please print legibly the name of the evaluating physician whose signature appears below.*)

Signature: _____ Date: _____

Please fax this completed form to the following dental office:

Office of _____ • Fax (___) ____ - _____ • Tel (___) ____ - _____

(*Dentist performing the procedure*)