Medical Consult for General Anesthesia

MEDICAL CONSULTATION

Patient Name: _____ **DOB:** _____

Dentist recommending patient for medical consult: _____

Proposed Dental Treatment: _____

_____

Indications for Medical Consult: _____

_____

_____

_____

Signature of dentist/anesthesiologist requesting consult: _____

PLEASE FAX/EMAIL most recent H&P, relevant labs/diagnostics

To be Completed by Physician

The patient indicated has _____ to anesthesia under their current health status.

- ☐ no increased risk
- ☐ a mild increased risk
- ☐ a moderately increased risk
- ☐ a highly increased risk

Recommendations for anesthesia: _____

_____

_____

Additional comments: _____

_____

_____

Physician: _____ Date: _____ Phone: _____

THANK YOU FOR YOUR TIME.

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