# REQUEST FOR MEDICAL CONSULTATION

Date _____

Patient Name _____ DOB _____ SSN _____
I authorize the release of any medical or other information necessary to process this request for medical consultation with your physician.

**Patient/Parent/Guardian** _____ **Date** _____

Dear Dr. _____ Treatment scheduled on _____

Our patient presented to a dental office in need of comprehensive dental treatment with the following medical conditions listed below. I would appreciate your evaluation and recommendation in regards to treating him/her. This consultation will be used in evaluating this patient's health status prior to rendering any treatment as well as any modifications needed for their dental care **under general anesthesia**. Thank you for helping to provide the best care for my patient.

**Dr. Sophia Tan, DDS, PLLC**
**Anesthesiologist**
**Tel: (503) 680-4406 Fax: (360) 882-3325 Email: sleepytimedoc@gmail.com**

Medical Condition(s):
1. _____ 3. _____
2. _____ 4. _____

Proposed Dental Treatment:
____Exam and Radiographs ____Fillings/Crowns ____Root canal therapy
____Teeth cleaning ____Extraction(s) ____Other: _____

Dental work will be done using:
____Local Anesthesia ____General Anesthesia (IV)
____IV Sedation ____At an **Outpatient** Dental Office

## SECTION TO BE COMPLETED BY THE PHYSICIAN (check and initial)

1. What is the patient's diagnosis? _____
2. Is the patient's medical status healthy enough to safely undergo the proposed treatment? YES_____ NO_____
3. Does the patient's medical condition require prophylactic antibiotic treatment? YES_____ NO_____
   - If you recommend a different prophylactic regimen form the American Heart Assoc., please indicate _____
4. Is there any contraindications/precautions for **dental treatment under general anesthesia**? YES_____ NO_____
   - If yes, please explain _____
5. Does the patient require any modification in their medical treatment/medications to undergo **general anesthesia**? YES_____ NO_____
   - If yes, please explain _____
6. Do you feel this patient's medical health status makes him/her suitable for **outpatient** surgery in a dental office? YES_____ NO_____

**If you would like to be contacted prior to this surgery, please check this box** ☐

Name (print) _____ M.D. Date _____

Signature _____ M.D. Phone # _____