DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

REQUEST FOR MEDICAL CLEARANCE PRIOR TO DENTAL PROCEDURE WITH CONSCIOUS SEDATION

The following patient is scheduled to have dental treatment performed under conscious sedation. This form will be attached to the patient's History and Physical. Please fax this form to Dr. Deidra Rondeno at ***(404) 942-0088****. Please call* ***(404) 942-0086*** *if you have any questions or require additional information.*

Patient: _____ ***DOB:*** _____

Proposed procedure: _____

Date of proposed procedure: _____

This patient has been examined by me and is deemed suitable for medical clearance for the above listed procedure under conscious sedation.

_____
MD Signature

_____
Date

Office Phone: _____ ***Fax:*** _____

For Office Use Only

Date: _____ ***Time:*** _____ ***ASA:*** *I II III*

Patient has been reassessed and is an appropriate candidate for Conscious Sedation.

_____***MD*** _____***DDS***

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PRE-OPERATIVE MEDICAL HISTORY AND PHYSICAL EXAMINATION	PATIENTS NAME: _____ DATE OF BIRTH: ____/____/_____ DATE OF PRE-OP EXAM: ____/____/_____

***** ALL sections of the form MUST be completed*****

PRE-OPERATIVE MEDICAL HISTORY

Past Medical History: _____

Current Medications: _____

_____

Is patient taking any form of cannabis? Yes ☐No ☐ If yes, please list below

_____

Allergies: _____

***** It is important to complete ALL sections *****

PRE- OPERATIVE PHYSICAL EXAM

Chest and Lungs:	Temp:
	BP:
Cardiovascular:	Pulse:
	Resp:
Neurological:	Weight:
Gastrointestinal:	
Mental Status:	
Pregnancy test: yes ⬭ no ⬭	Would doctor like blood drawn while patient is sedated? Yes ⬭ No ⬭
	If yes, please fax order/requisition along with diagnosis codes for all labs

Cleared for Sedation: ⬭ Not cleared: ⬭

Comments:

_____

_____ _____

MD SIGNATURE: **NPI** ***Date:***